Department of Veterans Affairs

Capital Asset Realignment for Enhanced Services

VISN 3

Market Plans

Attention

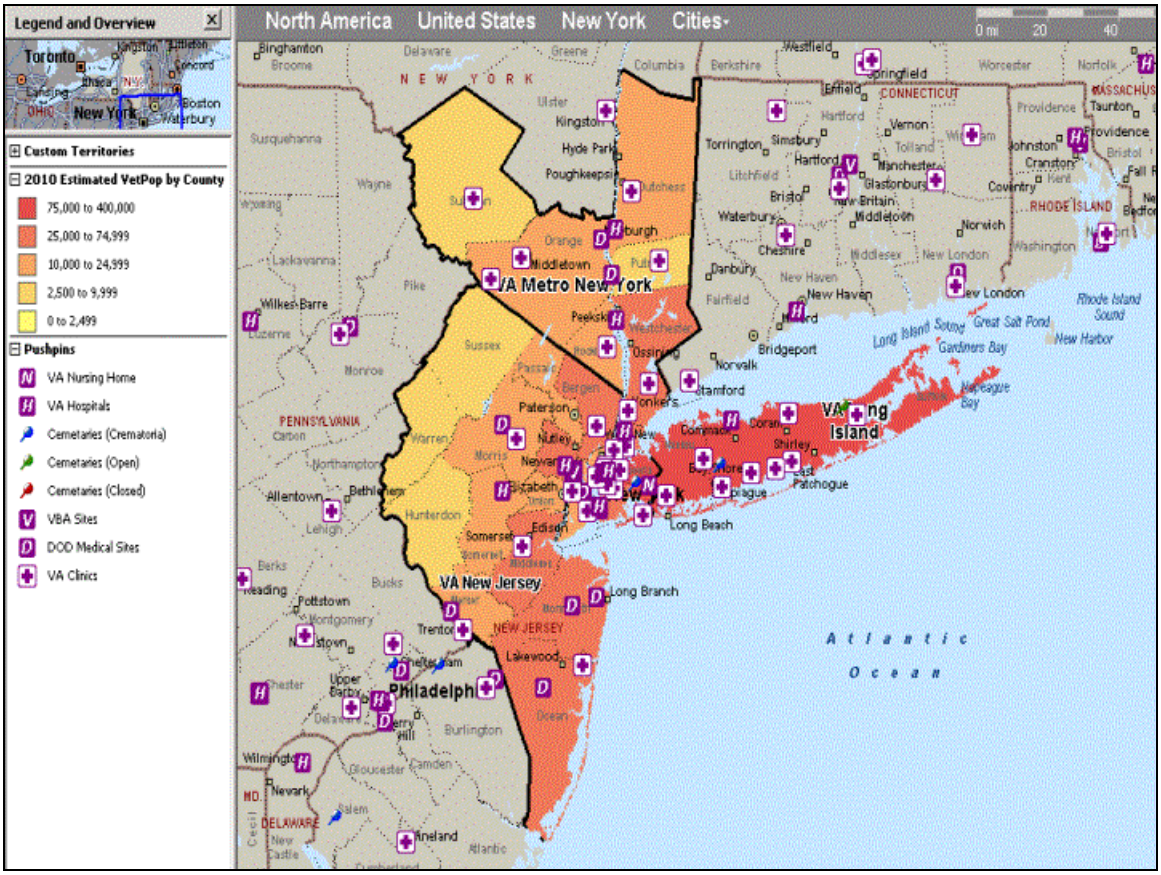
The VISNs developed the initial CARES Market plans under direction from the National CARES Program Office (NCPO). After these were submitted by the VISN, they were utilized as the basis for the National CARES Plan. However, the CARES National Plan includes policy decisions and plans made at the National Level which differ from the detailed Network Market Plans. Therefore, some National policy decisions that are in the National Plan are not reflected in the Network Market Plans. These initial VISN Market Plans have detailed narratives and data at the VISN, Market and Facility level and are available on the National CARES Internet Site : <<http://www.va.gov/CARES/>>.

Table of Contents – VISN 03

I. VISN Level Information

A. Description of the Network/Market/Facilities

1. Map of VISN Markets



2. Market Definitions

Market Designation: VISN 3 CARES is proposing three healthcare markets and two sub-markets, including the rationale for the delineation of each market within the Metro New York, Long Island and New Jersey market areas:

VA Metro New York Healthcare Market			
Market	**Includes**	**Rationale**	**Shared Counties**
VA Metro New York Healthcare Market **Code: 3B**	11 New York Counties	VA Metro New York Healthcare Market was identified based on natural referral patterns, coupled with knowledge of use patterns within the very specific markets and applying the market data provided. This market is divided into two sub markets based on geographic and veteran access supporting 544,000 veterans. This market has three healthcare systems (including a two campus healthcare system in the Hudson Valley area, a four campus healthcare system in the New York Harbor area and a facility in Bronx, NY). This market includes VA facilities in Castle Point, Montrose, Bronx, New York (Manhattan), Brooklyn, St. Albans (Queens) and a recently acquired one-acre parcel in Staten Island (transferred to the VA from the BRAC). This Market has 16 Community Based Clinics (excluding the Staten Island Clinic which is owned by the VA and included as a campus).	
Sub Market	**Includes**	**Rationale**	**Shared Counties**
VA North Metro/Hudson Valley Healthcare Sub Market **Code: 3B-1**	7 New York Counties	The limited population in the Hudson Valley counties compared to other counties within VISN 3 and the geographic distance lends a natural combination of these counties and the borough of the Bronx using the Bronx facility as the anchor tertiary care facility supporting the quality inpatient care provided by the Hudson Valley campuses. Additionally, as the only rural county identified within VISN 3 was Sullivan County within the Hudson Valley. These were the deciding factors to include this into one sub-market resulting in the VA North Metro/Hudson Valley Healthcare Market which supports 205,000	

		veterans. This market has two healthcare systems (including a two-campus medical center and a highly affiliated tertiary center in the Bronx.) This sub market has 10 community clinics.	
VA Southeast Metro New York Healthcare Sub Market **Code: 3B-2**	4 New York Counties	**The four counties making up the balance of the VA Metro New York Healthcare Market was identified as the VA Southeast Metro New York Healthcare Market. This market has one healthcare system including (four campuses and six community clinics. This Sub Market supports 340,000 veterans.**	
VA New Jersey Healthcare Market **Code: 3C**	14 New Jersey Counties	**The VA New Jersey Healthcare Market was constructed based upon an analysis of referral patterns supporting 358,000 veterans. The usage patterns are more absolute within VA New Jersey Healthcare Market than the VA Metro New York healthcare population. This market has one (two-campus) healthcare system and eight community clinics.**	
VA Long Island Healthcare Market **Code: 3A**	2 New York Counties	The VA Long Island Healthcare Market was constructed based upon an analysis of referral patterns. The usage patterns are more absolute within VA Long Island Healthcare Market than the VA Metro New York healthcare population supporting 219,000 veterans. This market has one medical center and three community clinics with six mental health clinics.	

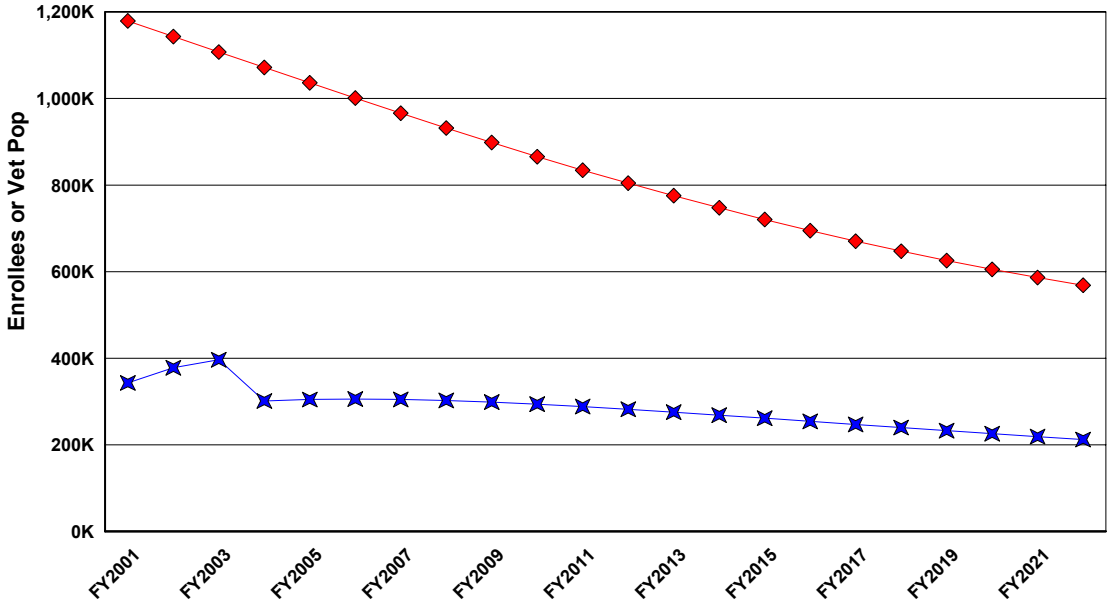
3. Facility List

VISN : 3				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Lyons				
561A4 Lyons	✓	✓	-	-
Montrose				
620 Hudson Valley HCS	✓	✓	-	-
620GA New City (Rockland County)	✓	-	-	-
620GB Carmel (Putnam County)	✓	-	-	-
620GD Middletown	✓	-	-	-
620GE Port Jervis	✓	-	-	-
620GF Harris (monticello)	✓	-	-	-
620GG Poughkeepsie	✓	-	-	-
New York				
630 New York Harbor HCS - NY Div.	✓	✓	✓	-
630B2 Soho	✓	-	-	-
630BZ New York SOC	✓	-	-	-
630GA Harlem	✓	-	-	-
630GD Brooklyn (Bedford-Stuyvesant)	✓	-	-	-
630GF Far Rockaway	✓	-	-	-
Northport				
632 Northport	✓	✓	✓	-
632GA Plainview	✓	-	-	-
632HA Lynbrook	-	-	-	✓
632HB Riverhead	-	-	-	✓
632HC Islip	-	-	-	✓
632HD Patchoque	-	-	-	✓
632HE Mt. Sinai	-	-	-	✓
632HF Lindenhurst	-	-	-	✓
632HG Plainview, 1485 Old Country Rd	-	-	-	✓
632HH Sayville	-	-	-	✓

632HX Westhampton	✓	-	-	-
632X2 Patchogue (Plainview)	✓	-	-	-
St.Albans				
630A5 New York Harbor HCS-St. Albans Campus	✓	-	-	-
VA Hudson Valley HCS				
620A4 Castle Point Division	✓	✓	-	-
VA New Jersey HCS				
561 New Jersey HCS (East Orange)	✓	✓	✓	-
561BZ Brick	✓	-	-	-
561GA Trenton	✓	-	-	-
561GB Elizabeth	✓	-	-	-
561GD Hackensack/Bergen County	✓	-	-	-
561GE Jersey City	✓	-	-	-
561GF New Brunswick	✓	-	-	-
561GG Newark	✓	-	-	-
561GH Morristown	✓	-	-	-
VA NY Harbor HCS				
630A4 New York Harbor HCS-Brooklyn-Poly Pl.	✓	✓	✓	-
630GB Staten Island	✓	-	-	-
630GC Chapel St	✓	-	-	-
VAMC Bronx NY				
526 Bronx	✓	✓	✓	-
526GA White Plains	✓	-	-	-
526GB Yonkers	✓	-	-	-
526GC South Bronx	✓	-	-	-
526GD Queens	✓	-	-	-

4. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



5. Planning Initiatives and Collaborative Opportunities

a. Effective Use of Resources

Effective Use of Resources		
PI?	**Issue**	**Rationale/Comments Re: PI**
Y	Small Facility Planning Initiative	VA Hudson Valley HCS: Castle Point Division is projected to require fewer than 40 acute care beds. The VISN should review potential quality of care issues for this facility and its parent as well as opportunities for reassigning inpatient workload and/or enhancing volume.
N	Small Facility Planning Initiative	Since the St. Albans Division of the VA New York Harbor HCS is a Long Term Care facility, the projection for fewer than 40 acute care beds is not considered a significant issue.
Y	Proximity 60 Mile Acute	The VISN is requested to consider mission changes and/or realignment of acute care facilities within the Metro New York Market. The data indicates that the Metro New York Market will require 83 fewer acute beds and 71 fewer Dom beds in 2022. Affected facility pairs include • VA New York HCS: New York and VA New York HCS: Brooklyn • Bronx and VA New York Harbor HCS: New York • Bronx and VA New York Harbor HCS: Brooklyn
N	Proximity 60 Mile Acute	Although the following facility pairs fall within the 60 mile proximity standard, they were not selected for PIs due to differing missions and impact of local transportation patterns (high volume): • VA New Jersey HCS: East Orange and VA New York Harbor HCS: New York • VA New Jersey HCS: East Orange and VA New York Harbor HCS: Brooklyn • VA New Jersey HCS: East Orange and VA New Jersey HCS: Lyons • Bronx and VA New Jersey HCS: East Orange • Bronx and VA Hudson Valley HCS: Castle Point • VA New Jersey HCS: Lyons and VA New York Harbor HCS: Brooklyn • VA New Jersey HCS: Lyons and VA New York Harbor HCS: New York • Bronx and Northport • VA Hudson Valley HCS: Montrose and VA New York

		Harbor HCS: New York • Bronx and VA New Jersey HCS: Lyons • VA New York HCS: Brooklyn and Northport • VA Hudson Valley HCS: Montrose and VA New York HCS: Brooklyn • VA New Jersey HCS: East Orange and VA Hudson Valley HCS: Montrose • VA New Jersey HCS: East Orange and Northport
Y	Proximity 120 Mile Tertiary	The VISN is requested to consider mission changes and/or realignment of the following tertiary care facilities that fall within the 120 mile proximity standard: • VA New York Harbor HCS: Brooklyn and VA New York HCS: New York • Bronx and VA New York Harbor HCS: New York • VA New Jersey HCS: East Orange and VA New York Harbor HCS: New York • VA New Jersey HCS: East Orange and VA New York Harbor HCS: Brooklyn • Bronx and VA New York Harbor HCS: Brooklyn • Bronx and VA New Jersey HCS: East Orange

Effective Use of Resources (con't)		
PI?	**Issue**	**Rationale/Comments Re: PI**
N	Proximity 120 Mile Tertiary	Although the following tertiary care facility pairs fall within the 120 mile proximity standard, they were not selected for PIs primarily due to local transportation patterns (high volume): • Bronx and Northport • VA New York Harbor HCS: New York and Northport • VA New York Harbor HCS: Brooklyn and Northport • VA New Jersey HCS: East Orange and Northport • Bronx and West Haven, CT (VISN 1) • VA New York Harbor HCS: New York and West Haven, CT (VISN 1) • VA New York Harbor HCS: Brooklyn and West Haven, CT (VISN 1) • VA New Jersey HCS: East Orange and West Haven, CT (VISN 1) • VA New York Harbor HCS: Brooklyn and Philadelphia, PA (VISN 4) • Northport and West Haven, CT (VISN 1) • VA New Jersey HCS: East Orange and Philadelphia, PA (VISN 4) • VA New York Harbor HCS: New York and Philadelphia, PA (VISN 4) • Bronx and Philadelphia, PA (VISN 4)
Y	Vacant Space	All VISNs are to develop plans to reduce vacant space by 10% in 2004 and 30% by 2005.

b. Special Disabilities

Special Disabilities Programs		
PI?	**Issue**	**Rationale/Comments**
N	Blind Rehabilitation	VISN is encouraged to establish a Visual Impairment Services Outpatient Program (VISOR) staffed by Blind Rehabilitation Outpatient Specialists and low vision specialists. In addition, plan for low vision care clinics at tertiary facilities.
N	Spinal Cord Injury and Disorders	VISN is requested to coordinate planning with VISNs 2 and 4 and with the Chief Consultant, Spinal Cord Injury & Disorders Strategic Health Care group regarding existing SCI beds and potential impact of other CARES PIs.

c. Collaborative Opportunities

Collaborative Opportunities for use during development of Market Plans		
CO?	**Collaborative Opportunities**	**Rationale/Comments**
Y	Enhanced Use	Lyons, Northport and St. Albans are identified in the top 15 High-Potential Enhanced Use Lease Opportunities for VHA. Montrose, Castle Point and Bronx are identified on the secondary list of EUs. The VISN should consider these in the development of their Market Plans.
Y	VBA	There is a potential opportunity for VBA/VHA collaboration at the Lyons Division of the VA New Jersey HCS. The VISN should review/analyze this in the development of the Market Plan.
Y	NCA	There are potential opportunities for NCA/VHA collaboration at the VA Hudson Valley HCS (Castle Point and/or Montrose Divisions). The VISN should consider these in the development of the Market Plan.
Y	DOD	There are potential opportunities for VA/DoD collaboration in the following locations: • Ainsworth Clinic (Ft. Hamilton) and the VA New York Harbor HCS: Brooklyn • Ft. Monmouth and the VA New Jersey HCS: East Orange • West Point and the VA Hudson Valley HCS: Montrose Division The VISN should consider these potential opportunities in the

		Development of their Market Plans.

d. Other Issues

Other Issues		
PI?	**Issue**	**Rationale/Comments**
-	None.	

e. Market Capacity Planning Initiatives

Long Island Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	93,516		**89,829**	**96%**	34,796	**37%**
	Treating Facility Based **	88,807		**74,314**	**84%**	26,874	**30%**
Specialty Care	Population Based *	108,934		**124,680**	**114%**	56,403	**52%**
	Treating Facility Based **	104,986		**107,634**	**103%**	47,607	**45%**

Metro New York Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	343,721		**155,712**	**45%**	9,838	**3%**
	Treating Facility Based **	369,098		**161,582**	**44%**	11,737	**3%**
Specialty Care	Population Based *	393,247		**154,087**	**39%**	6,549	**2%**
	Treating Facility Based **	412,027		**168,813**	**41%**	17,085	**4%**
Medicine	Population Based *	64,131		**10,663**	**17%**	(13,669)	**-21%**
	Treating Facility Based **	67,090		**10,901**	**16%**	(13,864)	**-21%**
Psychiatry	Population Based *	63125		**6916**	11%	-7971	**-13%**

	Treating Facility Based **	62324		**6452.14**	10%	-9167.61	**-15%**

New Jersey Market

Category	Type of Gap	FY2001 Baseline	Fy 2001 Modeled ***	FY 2012 Gap	FY 2012 % Gap	FY 2022 Gap	FY 2022 % Gap
Primary Care	Population Based *	148,935		**143,781**	**97%**	66,875	**45%**
	Treating Facility Based **	137,647		**120,562**	**88%**	54,136	**39%**
Specialty Care	Population Based *	139,252		**217,267**	**156%**	132,585	**95%**
	Treating Facility Based **	126,817		**185,000**	**146%**	112,217	**88%**
Medicine	Population Based *	21,013		**17,427**	**83%**	6,636	**32%**
	Treating Facility Based **	19,638		**16,504**	**84%**	6,497	**33%**
Psychiatry	Population Based *	46644		**12622**	27%	5500	**12%**
	Treating Facility Based **	47639		**12835.42**	27%	6244.22	**13%**

* – Population Based: Sum of the workload demand based on where the enrollee lives. Sum of the workload projections for the enrollees living in the counties geographically located in the Market. This is not necessarily where they go for care.

** – Treating Facility Based: Sum of the workload demand based on where the enrollee goes for care. Sum of the facility data for the facilities geographically located in the Market. (Due to the traffic or ever referral patterns, the population based and treating facility projections will not match at the market level, although nationally they will be equal)

*** – Modeled data is the Consultants projection based on what the workload **would have been if adjusted for community standards**.

6. Stakeholder Information

Summary narrative on key stakeholder issues by Market, and how the comments/concerns were incorporated in the Market Plan.

Stakeholder Narrative:

Stakeholders supporting the New York/New Jersey Veterans Integrated Service Network (VISN 3) have been kept involved and informed throughout the progression of the CARES process. The VISN staff held regular briefings with Network-level groups such as the Management Assistance Council, numerous VISN level committees such as the Executive Leadership Council. Communication modes consisted of face-to-face briefings, distribution of newsletters and bulletins, e-mails, mailings (newsletters), conference calls, employee meetings and website postings. At the Market level, a wide variety of stakeholders have been extensively briefed, consulted and involved -, including veterans service organizations, veterans groups, medical school affiliates, staff members and volunteers, local stakeholders, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, Dean's Committee meetings, and veteran council meetings. Comments were solicited through these forums as well as through encouragement of phone calls, letters, and the VISN Internet and Intranet websites.

Overall, the process has been viewed positively from the stakeholders. Some of the more frequent comments and questions included (with Network responses in parentheses):

1. Concern about possible facility closures, Small Facility PI and Proximity PI — (Comments from stakeholders were considered in the development of final proposed plan)

2. Concerns over multi-VISN coordination of SCI Services – (VISN 3 coordinated internal discussions with referring VISN's to develop a comprehensive plan which included planning from VISN's 2 and 4). (Participated in EPVA and PVA sponsored meetings)

3. Outreach to all stakeholders though all modes of communication exceeded 330,000 contacts.

4. Whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

5. Potential impact of war on data projections. (Present data projections do not include potential war impact, however, data will be re-run on an annual basis and adjustments made as needed. This is a long-term strategic planning process.)

Extensive efforts were made to educate our stakeholders, such as briefing on the IBM planning model, in depth discussions of the CARES process and our approach to meeting the timeframes and objectives of the program. Input provided by our stakeholders was considered throughout the CARES planning process by the individual facilities, markets and at the VISN levels.

Of particular note is VISN 3's leadership in bringing together 3 VISNs along with the EPVA and PVA to address the overall plan for SCI Care in the Northeast. This included several meetings and calls in addition to one face to face meeting with VISNs 2,3,4 and the EPVA, PVA and Dr. Hammond from VACO – which was hosted by the EPVA.

7. Collaboration with Other VISNs

Summary narrative of collaborations with neighboring VISNs, and result of collaborations. Include overview of Proximity issues across VISNs.

Collaboration with Other VISNs Narrative:

Background: SCI projection models were developed through the combined efforts of SCI&D SHG officials and the Office of the Actuary (OACT) in collaboration with the National CARES Program Office (NCPO).

The model recommended is based upon actual FY01 SCI 'user-enrollees' as a market share of the prevalence model estimates based upon zip code mapping of actual FY01 SCI enrollees who have used VHA at any time since 1988. By linking the current user-enrollees to the CARES demographic VetPop databases by VISN, projected utilization is derived by calculating a market share of priority groups 1-4 prevalence estimates (based upon Lasfarques et al., 1995) plus 25% of veterans with multiple sclerosis based on state latitude adjusted VISN multiple sclerosis prevalence rates based on Bandolier (2001) and Myhr et al. (2001).

Within the Northeast corridor, VISN 1 has a comprehensive SCI program within the greater Boston area located at the West Roxbury facility and supports the New England region. This led to the recommendation affecting VISN 3, which read:

"Other CARES planning issues relate to potential mission changes in VISN 3 for facilities that may affect SCI beds. The Chief Consultant, SCI&D, should work

closely with VISN 3 planners and neighboring VISN's (especially VISN's 2 and 4) to facilitate appropriate planning for any bed relocations."

As a result of this recommendation and the evaluation of the projections for SCI/D - we initiated meetings and conference calls with the Chief Consultant, SCI&D on February 19, 2003 to discuss an approach and to solicit her guidance.

On March 3, 2003 VISN 3 coordinated the first discussion between the senior leadership of VISN's 2, 3 and 4 to discuss the Spinal Cord Injury programs referral patterns and outline plans that have been developed based on existing CARES data to ensure these plans do not conflict with plans being put forward at other VISN's. Also to develop a strategic approach to Acute and LTC SCI beds, allocation of beds and impact of the opening of the SCI program in VISN 2 or VISN 4. Based on these discussions VISN 3 developed the approach to consolidate all SCI/D patient treatment at center of excellence to be located at the VA Medical Center, Bronx, NY. In effect, this would consolidate the three SCI programs within VISN 3 into one comprehensive unit. This plan was presented at the follow-up conference call with our neighboring VISN's on 3/28/03. Concurrently, during this period the EPVA had organized a face-to-face meeting in their Queens, NY offices to discuss the coordination efforts and referral patterns between the VISN's, which was well attended by all of the participating VISN's.

On April 4, 2003, VISN's 2,3 and 4 participated in a conference call along with Chief Consultant, SCI&D and the senior leadership of the EPVA and PVA. VISN's 2,3 and 4 outlined our plans which had been coordinated and discussed at which time we presented our preferred option to address this planning initiative which based on our analysis and discussions with referring VISN's and stakeholders, VISN 3 concluded the best approach to take in developing the CARES market plan for SCI is to shift all workload to the VA Medical Center Bronx, NY.

Proposal:

Network 3 proposes consolidating all acute inpatient Spinal Cord Injury Services at the Bronx VAMC by 2006. This would increase the number of acute care SCI beds at the Bronx VAMC from 62 to 66. A full spectrum of SCI outpatient care will be provided at two of the existing locations, the Bronx VAMC and the East Orange VAMC. Extended care services will be provided in 30 beds dedicated to SCI at the Bronx. There will be no decrease in the number of SCI Patients treated and no decrease in the number of beds to care for the SCI veterans it will remain 96 total beds.

This presentation was generally supported based on the discussion.

B. Resolution of VISN Level Planning Initiatives

1. Proximity Planning Initiatives (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Proximity Narrative:

Please review Proximity Summaries posted on the VSSC CARES Portal.

Proximity Planning Initiative between the East Orange Division of the VA New Jersey Health Care System (VANJ HCS) the Bronx VAMC and the NY divisions of the NY Harbor Health Care System (New York and Brooklyn)

1. Executive Summary:

As part of the CARES process, tertiary care medical centers located within 120 aerial miles of each other must consider mission changes and / or realignment of tertiary care facilities. The proximity planning initiatives are designed to eliminate unnecessary duplication. While there are many hospitals in the Northeast that fall within the defined 120 mile radius, Planning Initiatives (PI) were identified for only those facilities within a 25 mile radius which include the East Orange campus of the VANJ HCS, the Bronx VAMC and the NY and Brooklyn campuses of the NY Harbor HCS.

This review takes into consideration that the four facilities are located within a large densely populated urban area. The facilities are highly complex medical institutions that serve separate and distinct, major metropolitan populations. This is especially true for the East Orange campus of the VANJ HCS since it represents the only VA tertiary care facility in the entire state. Additionally, all facilities have numerous teaching affiliations and are major resources to medical education.

2. Special Disability Planning Initiative (if appropriate)

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

Your analysis should include the following:

1. Describe the impact that the planning initiative will have on the mandated funding levels for special disability programs:

    - SCI
    - Blind Rehab
    - SMI
    - TBI
    - Substance Abuse
    - Homeless
    - PTSD

2. Discuss how the planning initiative may affect, complement or enhance special disability services.

3. Describe any potential stakeholder issues revolving around special disabilities related to the planning initiative.

Special Disability Narrative:

VISN 3 has three Spinal Cord Injury Centers within a close proximity (less then 100 miles). The Centers are located at the Bronx VAMC, the East Orange Division of the New Jersey VA Health Care System, and the Castle Point Division of the Hudson Valley VA Health Care System the three programs combined have a total of 96 beds (76 acute and 20 LTC. VISN 3 is the referral for SCI veterans from VISN 2 and VISN 4. The following proposal allows the Network to address the historical imbalance in the number of Spinal Cord Injury Units and beds. The proposal is designed to:

Maintain the ability to treat all of the existing SCI patients, on both an inpatient and outpatient basis,

Maintain a comprehensive SCI outpatient program at the East Orange Division of the New Jersey VA Health Care System

Reduce the cost of SCI in VISN 3.

PROPOSAL:

Network 3 proposes consolidating all acute inpatient Spinal Cord Injury Services at the Bronx VAMC by 2006. This would increase the number of acute care SCI beds at the Bronx VAMC from 62 to 66. A full spectrum of SCI outpatient care will be provided at two of the existing locations, the Bronx VAMC and the East Orange VAMC. Extended care services will be provided in 30 beds dedicated to SCI at the Bronx. There will be no decrease in the number of SCI Patients treated and no decrease in the number of beds to care for the SCI veterans it will remain 96 total beds. Several meetings and conference calls were completed with VISN 2 and VISN 4 and VA's SCI Coordinator. Based on the cares SCI projections VISN 2 will develop a 20 bed SCI Center in Syracuse therefore a projected decrease in the number of referrals to CastlePoint. All tertiary care and acute care from VISN 2 were already referred to the Bronx VAMC. VISN 3 feels that there is no longer a need to maintain any SCI care at Castle Point. East Orange has an ADC of 7 in patients, with the possibility of VISN 4 developing an SCI Center in Philadelphia VAMC based on the cares model there is a projection of a decrease in referrals to the East Orange VAMC for SCI. The SCI patient population does warrant a comprehensive SCI outpatient Center to remain in East Orange.Meetings and Conference calls were held with PVA and EPVA. There appeared to be no controversy regarding VISN 3s proposal to integrate the three SCI centers. In 2003 dollars there is a projected savings in recurring cost to VISN 3 of $5.5 million annually.

C. VISN Identified Planning Initiatives

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria. (See Chapter 5 Attachment 3 guidebook and Market Plan handbook.)

Your analysis should include the following:

1. List all of the VISN PIs and provide a short summary. Post the entire summary documentation on the portal.

VISN Planning Initiatives Narrative:

No Impact

D. VISN Level Data Summary of Post Market Plan (Workload, Space, & Costs)

1. Inpatient Summary

a. Workload

	BDOC Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
INPATIENT CARE	Baseline FY 2001 BDOC	FY 2012 BDOC	FY 2022 BDOC	In House BDOC	Other BDOC	In House BDOC	Other BDOC	Net Present Value
Medicine	104,641	135,737	94,282	133,771	2,750	93,175	1,892	$ (32,750,152)
Surgery	44,295	46,966	32,417	46,833	166	32,339	110	$ (10,595,487)
Psychiatry	153,923	175,528	149,943	170,304	5,227	145,464	4,484	$ (22,760,130)
PRRTP	7,844	7,844	7,844	7,844	-	7,844	-	$ (375,526)
NHCU/Intermediate	728,322	728,322	728,322	338,022	390,300	338,022	390,300	$ (90,734,588)
Domiciliary	104,735	104,735	104,735	104,735	-	104,735	-	$ (8,572,345)
Spinal Cord Injury	23,978	23,978	23,978	23,978	-	23,978	-	$ (29,414,444)
Blind Rehab	-	-	-	-	-	-	-	$ -
Total	**1,167,738**	**1,223,110**	**1,141,520**	**825,487**	**398,443**	**745,557**	**396,786**	**$ (195,202,672)**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
INPATIENT CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Medicine	211,061	328,419	228,355	327,904	228,603	$ (32,750,152)
Surgery	57,011	92,299	63,860	92,216	63,827	$ (10,595,487)
Psychiatry	138,991	291,859	248,488	284,176	241,773	$ (22,760,130)
PRRTP	44,145	10,200	10,200	10,504	10,504	$ (375,526)
NHCU/Intermediate	428,693	441,891	441,891	447,331	447,331	$ (90,734,588)
Domiciliary	125,103	130,251	130,251	128,775	128,775	$ (8,572,345)
Spinal Cord Injury	66,164	65,219	65,219	56,971	56,971	$ (29,414,444)
Blind Rehab	-	-	-	-	-	$ -
Total	**1,071,168**	**1,360,137**	**1,188,263**	**1,347,877**	**1,177,784**	**$ (195,202,672)**

2. Outpatient Summary

a. Workload

	Clinic Stop Projections (from demand)			FY 2012 Projection (from solution)		FY 2022 Projection (from solution)		
Outpatient CARE	Baseline FY 2001 Stops	FY 2012 Stops	FY 2022 Stops	In House Stops	Other Stops	In House Stops	Other Stops	Net Present Value
Primary Care	595,551	952,008	688,298	917,970	34,042	664,102	24,201	$ (47,467,613)
Specialty Care	643,828	1,105,275	820,738	1,061,211	44,068	783,066	37,676	$ (248,497,927)
Mental Health	570,063	571,505	569,180	571,509	-	569,185	-	$ (32,975,372)
Ancillary& Diagnostic	691,729	1,184,984	935,338	1,174,266	10,721	926,446	8,896	$ (54,402,139)
Total	**2,501,171**	**3,813,772**	**3,013,554**	**3,724,956**	**88,831**	**2,942,799**	**70,773**	**$ (383,343,051)**

b. Space

	Space Projections (from demand)			Post CARES (from solution)		
Outpatient CARE	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Primary Care	301,334	524,846	380,483	524,845	380,482	$ (47,467,613)
Specialty Care	594,947	1,298,124	965,310	1,275,513	941,480	$ (248,497,927)
Mental Health	227,021	316,223	314,932	329,689	328,357	$ (32,975,372)
Ancillary& Diagnostic	561,200	868,091	683,998	855,800	674,323	$ (54,402,139)
Total	**1,684,502**	**3,007,284**	**2,344,724**	**2,985,847**	**2,324,642**	**$ (383,343,051)**

3. Non-Clinical Summary

	Space Projections (from demand)			Post CARES (from solution)		
NON-CLINICAL	Baseline FY 2001 DGSF	FY 2012 DGSF	FY 2022 DGSF	FY 2012 Projection	FY 2022 Projection	Net Present Value
Research	319,203	319,203	319,203	226,283	226,283	$ (18,012,559)
Admin	1,912,275	2,962,720	2,453,379	2,820,778	2,315,530	$ (59,185,428)
Outleased	280,458	280,458	280,458	80,000	170,000	N/A
Other	533,676	533,676	533,676	403,127	403,127	$ -
Vacant Space	1,001,997	-	-	1,307,375	1,831,396	$ 504,782,928
Total	**4,047,609**	**4,096,057**	**3,586,716**	**4,837,563**	**4,946,336**	**$ 427,584,941**

II. Market Level Information

A. Long Island Market

1. Description of Market

a. Market Definition

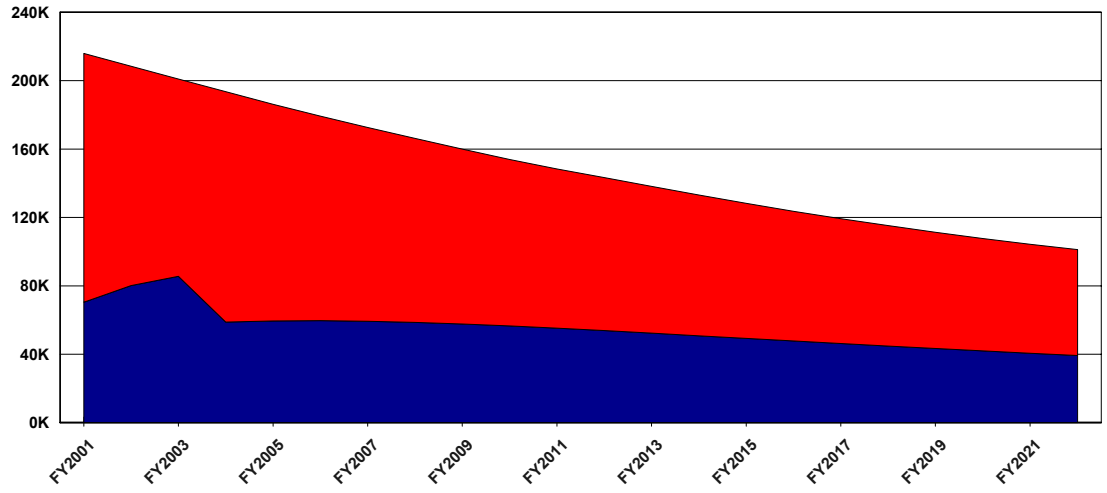
Market	Includes	Rationale	Shared Counties
VA Long Island Healthcare Market **Code: 3A**	2 New York Counties	The VA Long Island Healthcare Market was constructed based upon an analysis of referral patterns. The usage patterns are more absolute within VA Long Island Healthcare Market than the VA Metro New York healthcare population supporting 219,000 veterans. This market has one medical center and three community clinics with six mental health clinics.	

b. Facility List

Northport				
632 Northport	✓	✓	✓	-
632GA Plainview	✓	-	-	-
632HA Lynbrook	-	-	-	✓
632HB Riverhead	-	-	-	✓
632HC Islip	-	-	-	✓
632HD Patchoque	-	-	-	✓
632HE Mt. Sinai	-	-	-	✓
632HF Lindenhurst	-	-	-	✓
632HG Plainview, 1485 Old Country Rd	-	-	-	✓
632HH Sayville	-	-	-	✓
632HX Westhampton	✓	-	-	-
632X2 Patchogue (Plainview)	✓	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Long Island Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
N	Access to Primary Care					
N	Access to Hospital Care					
N	Access to Tertiary Care					
Y	Outpatient Specialty Care	Population Based	124,682	114%	56,406	52%
		Treating Facility Based	107,633	103%	47,606	45%
Y	Outpatient Primary Care	Population Based	89,831	96%	34,798	37%
		Treating Facility Based	74,315	84%	26,874	30%
N	Inpatient Psychiatry	Population Based	11	9%	-1	-1%
		Treating Facility Based	7	5%	-3	-2%
N	Inpatient Medicine	Population Based	14	25%	-8	-15%
		Treating Facility Based	12	21%	-10	-17%
N	Inpatient Surgery	Population Based	-6	-18%	-13	-44%
		Treating Facility Based	-6	-21%	-12	-45%
N	Outpatient Mental Health	Population Based	N/A	N/A	N/A	N/A
		Treating Facility Based	N/A	N/A	N/A	N/A

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Stakeholders supporting the New York/New Jersey Veterans Integrated Service Network (VISN 3) have been kept involved and informed throughout the progression of the CARES process. The VISN staff held regular briefings with Network-level groups such as the Management Assistance Council, numerous VISN level committees such as the Executive Leadership Council. Communication modes consisted of face-to-face briefings, distribution of newsletters and bulletins, e-mails, mailings (newsletters), conference calls, employee meetings and website postings. At the Market level, a wide variety of stakeholders have been extensively briefed, consulted and involved -, including veterans service organizations, veterans groups, medical school affiliates, staff members and volunteers, local stakeholders, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, Dean's Committee meetings, and veteran council meetings. Comments were solicited through these forums as well as through encouragement of phone calls, letters, and the VISN Internet and Intranet websites.

Overall, the process has been viewed positively from the stakeholders. Some of the more frequent comments and questions included (with Network responses in parentheses):

1. Concern about possible facility closures, Small Facility PI and Proximity PI — (Comments from stakeholders were considered in the development of final proposed plan)

2. Concerns over multi-VISN coordination of SCI Services – (VISN 3 coordinated internal discussions with referring VISN's to develop a comprehensive plan which included planning from VISN's 2 and 4). (Participated in EPVA and PVA sponsored meetings)

3. Outreach to all stakeholders though all modes of communication exceeded 330,000 contacts.

4. Whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

5. Potential impact of war on data projections. (Present data projections do not include potential war impact, however, data will be re-run on an annual basis and adjustments made as needed. This is a long-term strategic planning process.)

Extensive efforts were made to educate our stakeholders, such as briefing on the IBM planning model, in depth discussions of the CARES process and our approach to meeting the timeframes and objectives of the program. Input provided by our stakeholders was considered throughout the CARES planning process by the individual facilities, markets and at the VISN levels.

Of particular note is VISN 3's leadership in bringing together 3 VISNs along with the EPVA and PVA to address the overall plan for SCI Care in the Northeast. This included several meetings and calls in addition to one face to face meeting with VISNs 2,3,4 and the EPVA, PVA and Dr. Hammond from VACO – which was hosted by the EPVA.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

No Impact

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

VA Northport Medical Center Executive Summary

- Established/expanded Hoptel
- Established ER Observation Beds
- Established PAT/Ambulatory Surgery Optimization Program
- Established Total Knee Clinical Pathway
- Revised Total Hip Clinical Pathway
- Established partnership between Veterans Industries (VI) and Calverton National Cemetery (CNC).
- Established sharing agreements with DOD: U.S. Navy, 4220th U.S. Army Reserve, NY Army National Guard.
- Established sharing agreement with DOT: U.S. Coast Guard
- Established sharing agreements: AT&T Wireless, Omni Point, Sprint PCS, and Tricare.
- Established a leasing agreement with American Legion (Golf Course)
- Established PAT/Ambulatory Surgery Optimization Program
- Reduced inpatient Psychiatry Beds from 159 to 42
- Consolidated space for S/A Rehab and closed acute special program psychiatry beds
- Established PTSD Residential Treatment Program
- Established Intensive Case Management Program
- Completed the consolidation of the Day Hospital and Day Treatment programs into the Comprehensive Day Treatment Program (CDTP).
- Established Partial Hospitalization Program for Substance Abuse
- Consolidated Surgical Unit
- Re-designation of Rehab beds to Intermediate Medicine
- Consolidated Medical Unit
- Received designation as a Comprehensive Cancer Center
- Established Radiation Oncology Program
- Each of these initiatives resulted in the following:

Acute BDOC decreased from 143,672 to 83,358 (42%). In addition, there was a reduction in recidivism rates & LOS. Reduced costly pre-op testing. Significantly shifted surgical workload (operative procedures) from inpatient to outpatient basis.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**94%**	4,467	**96%**	1,889	**96%**	1,408
Hospital Care	**96%**	3,035	**96%**	2,266	**96%**	1,691
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Northport

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Potential uses: The most likely alternative use is for single-family residential, although community concerns could limit density significantly. Another possible use for portions of the site is for senior housing at various levels. Subdivision Potential: The most obvious area for subdivision is the current golf course. The southeast area could conceivably be subdivided, but would retain shared access with the main campus, which may be an issue with the town. The VAMC Northport, NY is developing an enhanced use proposal to outsource the 9-hole golf course.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	21,605	3,692	21,605	3,692	-	-	-	-	-	-	21,605	$ (4,090,900)
Surgery	6,610	(1,708)	6,610	(1,708)	-	-	-	-	-	-	6,610	$ (621,091)
Intermediate/NHCU	131,667	-	131,667	-	82,951	-	-	-	-	-	48,716	$ -
Psychiatry	46,277	2,317	46,277	2,317	-	-	-	-	-	-	46,277	$ (9,798,770)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**206,158**	**4,300**	**206,159**	**4,301**	**82,951**	**-**	**-**	**-**	**-**	**-**	**123,208**	**$ (14,510,761)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	163,121	74,314	163,121	74,314	16,313	-	-	-	-	-	146,808	$ (8,779,998)
Specialty Care	212,620	107,634	212,620	107,634	16,631	-	-	-	-	-	195,989	$ (69,625,038)
Mental Health	102,619	(192)	102,620	(191)	-	-	-	-	-	-	102,620	$ (1,956,725)
Ancillary & Diagnostics	206,811	121,128	206,811	121,128	3,069	-	-	-	-	-	203,742	$ (11,856,468)
Total	**685,171**	**302,884**	**685,172**	**302,885**	**36,013**	**-**	**-**	**-**	**-**	**-**	**649,159**	**$ (92,218,229)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	52,500	23,760	52,500	23,760	28,740	20,000	-	-	-	-	48,740	(3,760)
Surgery	10,973	1,665	10,973	1,665	9,308	3,000	-	-	-	-	12,308	1,335
Intermediate Care/NHCU	80,883	-	80,882	(1)	80,883	-	-	-	-	-	80,883	1
Psychiatry	74,969	54,010	74,969	54,010	20,959	58,000	-	-	-	-	78,959	3,990
PRRTP	-	(24,345)	-	(24,345)	24,345	-	-	-	-	-	24,345	24,345
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(945)	-	(945)	945	-	-	-	-	-	945	945
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**219,324**	**54,144**	**219,324**	**54,144**	**165,180**	**81,000**	**-**	**-**	**-**	**-**	**246,180**	**26,856**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	73,404	55,974	73,404	55,974	17,430	50,000	-	-	-	-	67,430	(5,974)
Specialty Care	222,188	167,644	215,588	161,044	54,544	-	130,000	-	-	-	184,544	(31,044)
Mental Health	55,312	19,479	56,441	20,608	35,833	18,000	-	-	-	-	53,833	(2,608)
Ancillary and Diagnostics	176,079	79,603	175,218	78,742	96,476	60,797	-	-	-	-	157,273	(17,945)
Total	**526,983**	**322,700**	**520,651**	**316,368**	**204,283**	**128,797**	**130,000**	**-**	**-**	**-**	**463,080**	**(57,571)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	55,347	-	22,753	(32,594)	55,347	-	-	-	-	-	55,347	32,594
Administrative	633,307	298,344	605,139	270,176	334,963	-	-	-	-	-	334,963	(270,176)
Other	96,637	-	96,637	-	96,637	-	-	-	-	-	96,637	-
Total	**785,291**	**298,344**	**724,529**	**237,582**	**486,947**	**-**	**-**	**-**	**-**	**-**	**486,947**	**(237,582)**

B. Metro New York Market

1. Description of Market

a. Market Definition

VA Metro New York Healthcare Market			
Market	**Includes**	**Rationale**	**Shared Counties**
VA Metro New York Healthcare Market **Code: 3B**	11 New York Counties	VA Metro New York Healthcare Market was identified based on natural referral patterns, coupled with knowledge of use patterns within the very specific markets and applying the market data provided. This market is divided into two sub markets based on geographic and veteran access supporting 544,000 veterans. This market has three healthcare systems (including a two campus healthcare system in the Hudson Valley area, a four campus healthcare system in the New York Harbor area and a facility in Bronx, NY). This market includes VA facilities in Castle Point, Montrose, Bronx, New York (Manhattan), Brooklyn, St. Albans (Queens) and a recently acquired one-acre parcel in Staten Island (transferred to the VA from the BRAC). This Market has 16 Community Based Clinics (excluding the Staten Island Clinic which is owned by the VA and included as a campus).	
Sub Market	**Includes**	**Rationale**	**Shared Counties**
VA North Metro/Hudson Valley Healthcare Sub Market **Code: 3B-1**	7 New York Counties	The limited population in the Hudson Valley counties compared to other counties within VISN 3 and the geographic distance lends a natural combination of these counties and the borough of the Bronx using the Bronx facility as the anchor tertiary care facility supporting the quality inpatient care provided by the Hudson Valley campuses. Additionally, as the only rural county identified within VISN 3 was Sullivan County within the Hudson Valley. These were the deciding factors to include this into one sub-market resulting in the VA North Metro/Hudson Valley Healthcare Market which supports 205,000 veterans. This market has two healthcare systems (including a two-campus medical center and a highly affiliated tertiary center in the Bronx.) This sub market has 10	

		community clinics.	
VA Southeast Metro New York Healthcare Sub Market **Code: 3B-2**	4 New York Counties	The four counties making up the balance of the VA Metro New York Healthcare Market was identified as the VA Southeast Metro New York Healthcare Market. This market has one healthcare system including (four campuses and six community clinics. This Sub Market supports 340,000 veterans.	

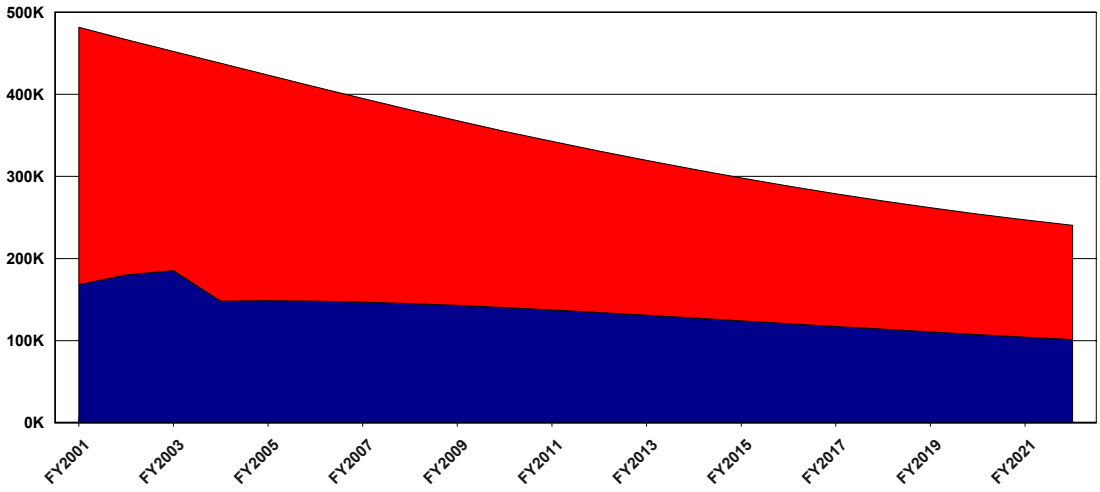
b. Facility List

VISN : 3				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Montrose				
620 Hudson Valley HCS	✔	✔	-	-
620GA New City (Rockland County)	✔	-	-	-
620GB Carmel (Putnam County)	✔	-	-	-
620GD Middletown	✔	-	-	-
620GE Port Jervis	✔	-	-	-
620GF Harris (monticello)	✔	-	-	-
620GG Poughkeepsie	✔	-	-	-
New York				
630 New York Harbor HCS - NY Div.	✔	✔	✔	-
630B2 Soho	✔	-	-	-
630BZ New York SOC	✔	-	-	-
630GA Harlem	✔	-	-	-
630GD Brooklyn (Bedford-Stuyvesant)	✔	-	-	-
630GF Far Rockaway	✔	-	-	-
St.Albans				
630A5 New York Harbor HCS-St. Albans Campus	✔	-	-	-
VA Hudson Valley HCS				
620A4 Castle Point Division	✔	✔	-	-
VA NY Harbor HCS				
630A4 New York Harbor HCS-Brooklyn-Poly Pl.	✔	✔	✔	-
630GB Staten Island	✔	-	-	-
630GC Chapel St	✔	-	-	-
VAMC Bronx NY				

526 Bronx	✔	✔	✔	-
526GA White Plains	✔	-	-	-
526GB Yonkers	✔	-	-	-
526GC South Bronx	✔	-	-	-
526GD Queens	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** -----**Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
Metro New York Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
N	Access to Primary Care					
N	Access to Hospital Care					
N	Access to Tertiary Care					
Y	Outpatient Primary Care	Population Based	155,714	45%	9,839	3%
		Treating Facility Based	161,586	44%	11,743	3%
Y	Outpatient Speciality Care	Population Based	154,091	39%	6,551	2%
		Treating Facility Based	168,822	41%	17,095	4%
Y	Inpatient Medicine	Population Based	34	17%	-44	-21%
		Treating Facility Based	35	16%	-45	-21%
Y	Inpatient Psychiatry	Population Based	22	11%	-26	-13%
		Treating Facility Based	21	10%	-30	-15%
N	Inpatient Surgery	Population Based	-1	-1%	-29	-34%
		Treating Facility Based	0	0%	-30	-32%
N	Outpatient Mental Health	Population Based	N/A	N/A	N/A	N/A
		Treating Facility Based	N/A	N/A	N/A	N/A

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Stakeholders supporting the New York/New Jersey Veterans Integrated Service Network (VISN 3) have been kept involved and informed throughout the progression of the CARES process. The VISN staff held regular briefings with Network-level groups such as the Management Assistance Council, numerous VISN level committees such as the Executive Leadership Council. Communication modes consisted of face-to-face briefings, distribution of newsletters and bulletins, e-mails, mailings (newsletters), conference calls, employee meetings and website postings. At the Market level, a wide variety of stakeholders have been extensively briefed, consulted and involved -, including veterans service organizations, veterans groups, medical school affiliates, staff members and volunteers, local stakeholders, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, Dean's Committee meetings, and veteran council meetings. Comments were solicited through these forums as well as through encouragement of phone calls, letters, and the VISN Internet and Intranet websites.

Overall, the process has been viewed positively from the stakeholders. Some of the more frequent comments and questions included (with Network responses in parentheses):

1. Concern about possible facility closures, Small Facility PI and Proximity PI — (Comments from stakeholders were considered in the development of final proposed plan)

2. Concerns over multi-VISN coordination of SCI Services – (VISN 3 coordinated internal discussions with referring VISN's to develop a comprehensive plan which included planning from VISN's 2 and 4). (Participated in EPVA and PVA sponsored meetings)

3. Outreach to all stakeholders though all modes of communication exceeded 330,000 contacts.

4. Whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

5. Potential impact of war on data projections. (Present data projections do not include potential war impact, however, data will be re-run on an annual basis and adjustments made as needed. This is a long-term strategic planning process.)

Extensive efforts were made to educate our stakeholders, such as briefing on the IBM planning model, in depth discussions of the CARES process and our approach to meeting the timeframes and objectives of the program. Input provided by our stakeholders was considered throughout the CARES planning process by the individual facilities, markets and at the VISN levels.

Of particular note is VISN 3's leadership in bringing together 3 VISNs along with the EPVA and PVA to address the overall plan for SCI Care in the Northeast. This included several meetings and calls in addition to one face to face meeting with VISNs 2,3,4 and the EPVA, PVA and Dr. Hammond from VACO – which was hosted by the EPVA.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Background: SCI projection models were developed through the combined efforts of SCI&D SHG officials and the Office of the Actuary (OACT) in collaboration with the National CARES Program Office (NCPO).

The model recommended is based upon actual FY01 SCI 'user-enrollees' as a market share of the prevalence model estimates based upon zip code mapping of actual FY01 SCI enrollees who have used VHA at any time since 1988. By linking the current user-enrollees to the CARES demographic VetPop databases by VISN, projected utilization is derived by calculating a market share of priority groups 1-4 prevalence estimates (based upon Lasfarques et al., 1995) plus 25% of veterans with multiple sclerosis based on state latitude adjusted VISN multiple sclerosis prevalence rates based on Bandolier (2001) and Myhr et al. (2001).

Within the Northeast corridor, VISN 1 has a comprehensive SCI program within the greater Boston area located at the West Roxbury facility and supports the New England region. This led to the recommendation affecting VISN 3, which read:

"Other CARES planning issues relate to potential mission changes in VISN 3 for facilities that may affect SCI beds. The Chief Consultant, SCI&D, should work closely with VISN 3 planners and neighboring VISN's (especially VISN's 2 and 4) to facilitate appropriate planning for any bed relocations."

As a result of this recommendation and the evaluation of the projections for SCI/D - we initiated meetings and conference calls with the Chief Consultant, SCI&D on February 19, 2003 to discuss an approach and to solicit her guidance.

On March 3, 2003 VISN 3 coordinated the first discussion between the senior leadership of VISN's 2, 3 and 4 to discuss the Spinal Cord Injury programs referral patterns and outline plans that have been developed based on existing CARES data to ensure these plans do not conflict with plans being put forward at other VISN's. Also to develop a strategic approach to Acute and LTC SCI beds, allocation of beds and impact of the opening of the SCI program in VISN 2 or VISN 4. Based on these discussions VISN 3 developed the approach to consolidate all SCI/D patient treatment at center of excellence to be located at the VA Medical Center, Bronx, NY. In effect, this would consolidate the three SCI programs within VISN 3 into one comprehensive unit. This plan was presented at the follow-up conference call with our neighboring VISN's on 3/28/03. Concurrently, during this period the EPVA had organized a face-to-face meeting

in their Queens, NY offices to discuss the coordination efforts and referral patterns between the VISN's, which was well attended by all of the participating VISN's.

On April 4, 2003, VISN's 2,3 and 4 participated in a conference call along with Chief Consultant, SCI&D and the senior leadership of the EPVA and PVA. VISN's 2,3 and 4 outlined our plans which had been coordinated and discussed at which time we presented our preferred option to address this planning initiative which based on our analysis and discussions with referring VISN's and stakeholders, VISN 3 concluded the best approach to take in developing the CARES market plan for SCI is to shift all workload to the VA Medical Center Bronx, NY.

Proposal:

Network 3 proposes consolidating all acute inpatient Spinal Cord Injury Services at the Bronx VAMC by 2006. This would increase the number of acute care SCI beds at the Bronx VAMC from 62 to 66. A full spectrum of SCI outpatient care will be provided at two of the existing locations, the Bronx VAMC and the East Orange VAMC. Extended care services will be provided in 30 beds dedicated to SCI at the Bronx. There will be no decrease in the number of SCI Patients treated and no decrease in the number of beds to care for the SCI veterans it will remain 96 total beds.

This presentation was generally supported based on the discussion.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

Bronx VA Medical Center Executive Summary

In order to maintain quality patient care by increasing staff at the patient care level in a declining resource environment, the Bronx VA Medical Center has reorganized many functions since 1995. The goals of this reorganization were to: focus on the patient; to ensure the appropriateness of inpatient care; to shift to ambulatory care; to revitalize research; and to support the network medical centers. As part of this patient centered care, the Bronx VAMC implemented Patient Care Centers, reorganized clinics into practices, expanded staff roles, developed new integrated staff functions, re-deployed traditional services, and implemented service centers.

VA Hudson Valley Healthcare System Executive Summary

The two facilities (Castle Point VAMC and Montrose VAMC) were integrated in 1997 and became VA Hudson Valley HCS. VAHV and its "sister " facility, Bronx VAMC, have traditionally had a close relationship and the Bronx serves as the referral center for secondary and tertiary medical and surgical care for veterans in the area.

VA New York Harbor Healthcare System Executive Summary

The Southeast Metro New York Market has been instrumental in accomplishing the re-direction of services to meet patient needs. To illustrate this, the following points are presented:

- Examination of independent facilities in this market began in 1997. It became clear that service redundancies existed. In order to meet these challenges, it was determined to investigate facility integration as a means to achieve efficiencies and effective resource use.
- Integration was informally begun in August 1997. The goals of integrating the two facilities included:

+ Increase access to all veterans
+ Expand the range of services
+ Enhance coordination and continuity of patient care
+ Enhance research and education programs
+ Improve management and utilization of resources

· Integration Plan was submitted October 1998
· Formal integration of the Brooklyn VAMC including the St. Alban's campus and the New York VAMC to form the VA New York Harbor Healthcare System was given in January 1999.

· Since the integration the following actions have been implemented:
+ Integrated Administrative Services
+ Integrated Mental Health Services
+ Integrated Pathology and Laboratory Service
+ Integrated Dental Services
+ Integrated Diagnostic Imaging functions
+ Integrated Anesthesiology management
+ Consolidated inpatient units (e.g., psychiatry, ICUs, oncology)

· Our continuing mission is to further refine, integrate and consolidate programs and services to ensure that easy access and high quality of veteran care is met.

In summary VA New York Harbor Healthcare System (Southeast Metro New York Market) has faced and met many challenges before the CARES initiatives were introduced. This market has consolidated and integrated services. Access to care has improved. Quality of healthcare continues to be strong. Efforts to further reduce duplicative services are in progress.

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**99%**	1,481	**99%**	1,087	**99%**	820
Hospital Care	**100%**	143	**100%**	94	**100%**	81
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Bronx

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

A. Proximity: 60 mile Acute Care ServicesThe Bronx VAMC is a tertiary care facility consisting of 225 operating acute care beds and a 112 bed extended care facility. All data for acute care bed days of care and referrals were reviewed. The projections show an increase in all acute care BDOC and through 2012 then a decrease in BDOC through 2022. In most areas the decrease is back to the baseline in 2001. There were also several VISN 3 initiatives in the Metro New York Area reviewed that would have a direct impact on the Bronx VAMC in the future. The mission change of one of the Harbor Healthcare System's Medical Centers and the mission change of the Montrose VAMC possibly in 2012 will have a direct impact on the Bronx VAMC. The Bronx VAMC is presently the acute care referral center for the Hudson Valley Healthcare System. It was determined based on the distance from the CastlePoint VAMC and its constituency and the proposed changes in other medical centers in the Metro NY area that the Bronx should remain as the acute care referral center. There were no other plans considered.

B. Proximity Issue: 120 mile Tertiary Care ServicesAll data for tertiary care was reviewed including all of the specialty care. The Bronx VAMC is a highly affiliated medical center, a major teaching center with the largest research program in the VISN. The Bronx VAMC is the tertiary care referral center for the Hudson Valley Healthcare system. It also is the SCI tertiary referral center for VISN, 2,3 and 4. Many of the sites are more than 120 miles from a SCI referral center. In order to ensure the highest level of care for the 62 bed spinal cord unit and according to the SCI guidelines a SCI referral medical center must remain tertiary care. In addition the proposed changes in the Harbor Healthcare System and in SCI for the VISN it was determined that the Bronx VAMC should remain tertiary care.There were no other plans considered.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	26,374	6,613	26,374	6,613	-	-	-	-	-	-	26,374	$ (4,090,900)
Surgery	9,287	739	9,288	740	-	-	-	30	-	-	9,318	$ (621,091)
Intermediate/NHCU	68,137	-	68,137	-	25,893	-	-	-	-	-	42,244	$ -
Psychiatry	12,985	1,241	12,985	1,241	-	-	-	-	-	-	12,985	$ (9,798,770)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	17,014	-	21,783	4,769	-	-	-	-	-	-	21,783	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**133,797**	**8,593**	**138,567**	**13,363**	**25,893**	**-**	**-**	**30**	**-**	**-**	**112,704**	**$ (14,510,761)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	118,964	37,288	118,964	37,289	1,190	-	-	-	-	-	117,774	$ (8,779,998)
Specialty Care	136,261	42,370	136,261	42,370	2,726	-	-	-	-	-	133,535	$ (69,625,038)
Mental Health	84,738	(148)	84,738	(148)	-	-	-	-	-	-	84,738	$ (1,956,725)
Ancillary & Diagnostics	162,774	43,560	162,774	43,561	-	-	-	-	-	-	162,774	$ (11,856,468)
Total	**502,736**	**123,071**	**502,737**	**123,072**	**3,916**	**-**	**-**	**-**	**-**	**-**	**498,821**	**$ (92,218,229)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	61,188	32,448	61,188	32,448	28,740	13,714	-	-	-	-	61,380	192
Surgery	20,526	11,218	20,593	11,285	9,308	9,000	-	-	-	-	24,148	3,555
Intermediate Care/NHCU	63,606	(17,277)	63,605	(17,278)	80,883	-	-	-	-	-	63,606	1
Psychiatry	21,036	77	21,036	77	20,959	-	10,000	-	-	-	26,661	5,625
PRRTP	-	(24,345)	-	(24,345)	24,345	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(945)	56,971	56,026	945	-	120,000	-	-	-	164,498	107,527
Blind Rehab	44,498	44,498	-	-	-	-	-	-	-	-	-	-
Total	**210,854**	**45,674**	**223,393**	**58,213**	**165,180**	**22,714**	**130,000**	**-**	**-**	**-**	**340,293**	**116,900**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	63,598	46,168	63,598	46,168	17,430	-	15,000	-	-	-	60,692	(2,906)
Specialty Care	156,237	101,693	156,236	101,692	54,544	-	60,000	-	-	-	157,032	796
Mental Health	46,979	11,146	47,453	11,620	35,833	-	-	-	-	-	44,233	(3,220)
Ancillary and Diagnostics	112,314	15,838	112,314	15,838	96,476	-	15,000	-	-	-	106,024	(6,290)
Total	**379,128**	**174,845**	**379,601**	**175,318**	**204,283**	**-**	**90,000**	**-**	**-**	**-**	**367,981**	**(11,620)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	100,518	45,171	76,605	21,258	55,347	-	-	-	-	-	100,518	23,913
Administrative	220,960	(114,003)	216,578	(118,385)	334,963	-	-	-	-	-	179,973	(36,605)
Other	39,046	(57,591)	39,046	(57,591)	96,637	-	-	-	-	-	39,046	-
Total	**360,524**	**(126,423)**	**332,229**	**(154,718)**	**486,947**	**-**	**-**	**-**	**-**	**-**	**319,537**	**(12,692)**

4. Facility Level Information – Hudson Valley

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

Objectives:

This study of the 27-bed acute care, 75-bed NHCU, and 20-bed LTC SCI/D Castle Point Campus of the VA Hudson Valley Healthcare System (HVHCS) will address the following objectives:

§ To assure that appropriate quality of care is provided in a cost-effective manner whereby quality includes clinical proficiency across the spectrum of care, safe environment and appropriate facilities.
§ To ensure that the unit is fully evaluated and that alternatives are developed that may provide for a more efficient utilization of resources and improved quality of care.
§ To fully consider the role of the campus in meeting projected patient population being the only facility between the largest urban population in the United States and Albany, NY.

Additionally, we will provide an understanding of the active achievements of the facility and VISN senior management to recognize the opportunities for reorganization, implementation and results. The remainder of this study will describe an assessment of the current environment and an in depth analysis of the following two options:

§ Option A: Move workload from VA Hudson Valley HCS (Montrose Campus) to the (Castle Point Campus); retain outpatient and domiciliary services at Montrose; and outsource majority of campus via Enhanced Use.

§ Option B: Consolidate the Castle Point and Montrose Campuses by closing the Montrose Campus and transferring all workload to Castle Point in FY 2012. This would require contracting with local community hospitals and significant referrals to the VA Medical Center Bronx, NY.

Analysis:

As previously mentioned, the two alternatives being evaluated are as follows:

§ Option A: Move workload from VA Hudson Valley HCS (Montrose Campus) to the (Castle Point Campus); retain outpatient and domiciliary services at Montrose; and outsource majority of campus via Enhanced Use.

§ Option B: Consolidate the Castle Point and Montrose Campuses by closing the Montrose Campus and transferring all workload to Castle Point in FY 2012. This would require contracting with local community hospitals and significant referrals to the VA Medical Center Bronx, NY.

The following analysis demonstrates that several key issues were considered in developing the VISN CARES Market Plan with Option A as a major component.
Conclusion

The VA HVHCS has undergone significant realignment and consolidation. Our proposed CARES market plan, supported by a thorough analysis of key considerations, will be the vehicle to continue this process. The basic conceptual design of the VISN recommended Option "A" would be to relocate nursing home and inpatient psychiatric services to Castle Point and maintain outpatient and residential services at Montrose. In addition, Spinal Cord Injury services will be transferred from the Castle Point Campus to the Bronx VAMC and plans would continue for enhanced use leasing. This alternative will meet our objectives by ensuring that our veterans maintain access to quality care while allowing efficient utilization of resources.

(abbreviated version of original narrative (posted on the CARES Portal)

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

1. The VISN 3 CARES Committee, Facility and VISN level leadership has activity engaged DoD throughout the CARES process. This includes involving two DoD participants to the internal VISN 3 CARES Committee from Health Affairs, TRICARE Region 1. They had access and information on all developmental aspects of the CARES Market Plan and provided valuable assistance and insight. To speak to the specific VA/DoD initiatives identified by the National CARES Process please see the specific initiative and status bulleted below:

§ VA New Jersey HCS and Ft. Monmouth, NJ Collaboration – We are happy to announce due to the CARES process and with the support of the DoD and congressional support within New Jersey, VISN 3 has been approved to site an active CBOC on the Ft. Monmouth, NJ site. This is anticipated to open sometime after June FY 03.

§ VA New York Harbor HCS (Brooklyn Campus) and Ft. Hamilton Army Base – This collaboration has occurred over the years, and the Brooklyn Campus is thought to be one of the more active VA/DoD sharing activities within the Northeast Region. The Ft. Hamilton Army Base abuts the Brooklyn Campus and the Ainsworth Clinic that supports the Army Garrison and the Brooklyn Campus has worked together organizationally for a number of years. In fact, one of the senior physicians at the clinic is a part-time DoD employee and part-time VA employee. As a result of the CARES initiative, aside of further collaboration is an important designation of the site to be "co-located". This will offer additional support to development of healthcare providing services to both DoD and VA beneficiaries.

§ VA Hudson Valley HCS and West Point/Keller Army Medical Center – Through the CARES process, the leadership has worked with the West Point command and did not meet with the high level of success as the New Jersey and Brooklyn initiatives. This is due to the very different missions of the facilities, specifically Montrose is a long-term psychiatry/ Domiciliary/Homeless etc. and West Point is training the young future leaders of DoD. Additionally, during the CARES process the West Point – Keller AMC leadership changed and slowed down local discussions. The commitment of both organizations is to find common services and to work to develop agreements to enhance services to the beneficiaries.

2. Investigate joint resident training in active agreements and collaborations.

3. Review High Tech/High Cost equipment inventories (e.g. MRI, Pet Scanners, IRM services, etc.) for possible joint VA/DoD actions.

4. Review support services (e.g. laundry, medical incinerators, etc.) for possible joint VA/DoD actions.

5. Emergency Preparedness – including continuing supporting reservists activated in the days after 9/11 and active collaboration with DoD and other local state and federal agencies related to preparedness.

6. Possibility for Joint Research collaboration.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

The VA Hudson Valley Healthcare System (Castle Point Campus) has entered discussions with NCA to site a cemetery at the Castle Point Campus. Land is available, NCA to assess feasibility.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	3,899	1,120	3,900	1,121	-	-	-	781	-	-	4,681	$ (16,429,492)
Surgery	44	(23)	44	(23)	-	-	44	-	-	-	-	$ 1,757,999
Intermediate/NHCU	52,254	-	133,394	81,140	42,687	-	-	-	-	-	90,707	$ (336,411,489)
Psychiatry	174	(80)	25,141	24,887	-	-	-	-	-	-	25,141	$ (112,132,274)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$ -
Spinal Cord Injury	4,861	-	1,382	(3,479)	-	-	-	-	-	-	1,382	$ 40,236,185
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**61,231**	**1,016**	**163,861**	**103,646**	**42,687**	**-**	**44**	**781**	**-**	**-**	**121,911**	**$ (422,979,071)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	43,158	11,476	43,159	11,477	-	-	-	-	-	-	43,159	$ (3,116,575)
Specialty Care	47,805	7,409	66,276	25,880	-	-	-	-	-	-	66,276	$ (54,439,718)
Mental Health	6,048	148	41,234	35,334	-	-	-	-	-	-	41,234	$ (61,032,921)
Ancillary & Diagnostics	100,082	31,551	127,839	59,308	-	-	-	-	-	-	127,839	$ (30,347,807)
Total	**197,093**	**50,584**	**278,508**	**131,999**	**-**	**-**	**-**	**-**	**-**	**-**	**278,508**	**$ (148,937,021)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	9,360	2,410	11,234	4,284	6,950	3,500	-	-	-	-	10,450	(784)
Surgery	73	73	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	37,466	-	95,642	58,176	37,466	-	70,000	-	-	-	107,466	11,824
Psychiatry	282	282	40,728	40,728	-	-	40,000	-	-	-	40,000	(728)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	(9,040)	-	(9,040)	9,040	-	-	-	-	-	9,040	9,040
Blind Rehab	9,040	9,040	-	-	-	-	-	-	-	-	-	-
Total	**56,221**	**2,765**	**147,604**	**94,148**	**53,456**	**3,500**	**110,000**	**-**	**-**	**-**	**166,956**	**19,352**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	32,369	9,266	32,369	9,266	23,103	-	12,000	-	-	-	35,103	2,734
Specialty Care	52,586	24,890	72,904	45,208	27,696	-	42,000	-	-	-	69,696	(3,208)
Mental Health	5,020	(6,127)	34,224	23,077	11,147	-	20,000	-	-	-	31,147	(3,077)
Ancillary and Diagnostics	64,052	42,666	81,817	60,431	21,386	-	40,000	-	-	-	61,386	(20,431)
Total	**154,027**	**70,695**	**221,314**	**137,982**	**83,332**	**-**	**114,000**	**-**	**-**	**-**	**197,332**	**(23,982)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	-	-	838	838	-	-	-	838	-	-	838	-
Administrative	178,711	62,228	428,090	311,607	116,483	-	250,000	-	-	-	366,483	(61,607)
Other	48,096	-	48,096	-	48,096	-	-	-	-	-	48,096	-
Total	**226,807**	**62,228**	**477,024**	**312,445**	**164,579**	**-**	**250,000**	**838**	**-**	**-**	**415,417**	**(61,607)**

5. Facility Level Information – Montrose

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

Objectives:

This study of the 27-bed acute care, 75-bed NHCU, and 20-bed LTC SCI/D Castle Point Campus of the VA Hudson Valley Healthcare System (HVHCS) will address the following objectives:

§ To assure that appropriate quality of care is provided in a cost-effective manner whereby quality includes clinical proficiency across the spectrum of care, safe environment and appropriate facilities.

§ To ensure that the unit is fully evaluated and that alternatives are developed that may provide for a more efficient utilization of resources and improved quality of care.

§ To fully consider the role of the campus in meeting projected patient population being the only facility between the largest urban population in the United States and Albany, NY.

Additionally, we will provide an understanding of the active achievements of the facility and VISN senior management to recognize the opportunities for reorganization, implementation and results. The remainder of this study will describe an assessment of the current environment and an in depth analysis of the following two options:

§ Option A: Move workload from VA Hudson Valley HCS (Montrose Campus) to the (Castle Point Campus); retain outpatient and domiciliary services at Montrose; and outsource majority of campus via Enhanced Use.

§ Option B: Consolidate the Castle Point and Montrose Campuses by closing the Montrose Campus and transferring all workload to Castle Point in FY 2012. This would require contracting with local community hospitals and significant referrals to the VA Medical Center Bronx, NY.

Analysis:

As previously mentioned, the two alternatives being evaluated are as follows:

§ Option A: Move workload from VA Hudson Valley HCS (Montrose Campus) to the (Castle Point Campus); retain outpatient and domiciliary services at Montrose; and outsource majority of campus via Enhanced Use.

§ Option B: Consolidate the Castle Point and Montrose Campuses by closing the Montrose Campus and transferring all workload to Castle Point in FY 2012. This would require contracting with local community hospitals and significant referrals to the VA Medical Center Bronx, NY.

The following analysis demonstrates that several key issues were considered in developing the VISN CARES Market Plan with Option A as a major component.
Conclusion

The VA HVHCS has undergone significant realignment and consolidation. Our proposed CARES market plan, supported by a thorough analysis of key considerations, will be the vehicle to continue this process. The basic conceptual design of the VISN recommended Option "A" would be to relocate nursing home and inpatient psychiatric services to Castle Point and maintain outpatient and

residential services at Montrose. In addition, Spinal Cord Injury services will be transferred from the Castle Point Campus to the Bronx VAMC and plans would continue for enhanced use leasing. This alternative will meet our objectives by ensuring that our veterans maintain access to quality care while allowing efficient utilization of resources.

(abbreviated version of original narrative (posted on the CARES Portal)

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

1. The VISN 3 CARES Committee, Facility and VISN level leadership has activity engaged DoD throughout the CARES process. This includes involving two DoD participants to the internal VISN 3 CARES Committee from Health Affairs, TRICARE Region 1. They had access and information on all developmental aspects of the CARES Market Plan and provided valuable assistance and insight. To speak to the specific VA/DoD initiatives identified by the National CARES Process please see the specific initiative and status bulleted below:

§ VA New Jersey HCS and Ft. Monmouth, NJ Collaboration – We are happy to announce due to the CARES process and with the support of the DoD and congressional support within New Jersey, VISN 3 has been approved to site an active CBOC on the Ft. Monmouth, NJ site. This is anticipated to open sometime after June FY 03.

§ VA New York Harbor HCS (Brooklyn Campus) and Ft. Hamilton Army Base – This collaboration has occurred over the years, and the Brooklyn Campus is thought to be one of the more active VA/DoD sharing activities within the Northeast Region. The Ft. Hamilton Army Base abuts the Brooklyn Campus and the Ainsworth Clinic that supports the Army Garrison and the Brooklyn Campus has worked together organizationally for a number of years. In fact, one of the senior physicians at the clinic is a part-time DoD employee and part-time VA employee. As a result of the CARES initiative, aside of further collaboration is an important designation of the site to be "co-located". This will offer additional support to development of healthcare providing services to both DoD and VA beneficiaries.

§ VA Hudson Valley HCS and West Point/Keller Army Medical Center – Through the CARES process, the leadership has worked with the West Point

command and did not meet with the high level of success as the New Jersey and Brooklyn initiatives. This is due to the very different missions of the facilities, specifically Montrose is a long-term psychiatry/ Domiciliary/Homeless etc. and West Point is training the young future leaders of DoD. Additionally, during the CARES process the West Point – Keller AMC leadership changed and slowed down local discussions. The commitment of both organizations is to find common services and to work to develop agreements to enhance services to the beneficiaries.

2. Investigate joint resident training in active agreements and collaborations.

3. Review High Tech/High Cost equipment inventories (e.g. MRI, Pet Scanners, IRM services, etc.) for possible joint VA/DoD actions.

4. Review support services (e.g. laundry, medical incinerators, etc.) for possible joint VA/DoD actions.

5. Emergency Preparedness – including continuing supporting reservists activated in the days after 9/11 and active collaboration with DoD and other local state and federal agencies related to preparedness.

6. Possibility for Joint Research collaboration.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

The VA Hudson Valley Healthcare System (Montrose Campus) has entered discussions with NCA to site a cemetery at the Montrose Campus. Land is available, NCA to assess feasibility.

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Enhanced Use Opportunities -- Development of vacant land and buildings:

Option "A" also plans for outsourcing using the Enhanced Use legislation retaining only a small percentage of the original acreage and infrastructure for VA use. During the 1990's, the VA HVHCS shifted from providing inpatient bed services to community and hospital based outpatient services. As the Castle Point and Montrose campuses were integrating and consolidating services, much of the land and buildings, particularly on the Montrose campus, became vacant and available for sharing and leasing.
Three buildings (7, 8 and 9) at the Castle Point campus were closed over several years by relocating the administrative staff into vacated spaces of closed medical, surgical and nursing home units in the main hospital complex. Use of Space and other formal lease agreements have been implemented, primarily with the NY State Police and the Immigration and Naturalization Service, to occupy most of these three buildings and providing revenues to suppport patient care activities. At the Montrose campus during 1996 and 1997, closure of numerous buildings occurred. A major initiative was undertaken to use the enhanced use lease concept to develop the vacant buildings and land for non-VA use. An RFQ was sent forward by VA Hudson Valley HCS during the autumn of 2000 for a public/private development of VA buildings and or land for uses including, but not limited to, affordable senior housing, assisted living, enriched housing or other similar life care services.

In May 2001, an asset manager was chosen to develop the project. In October of 2001 the Secretary of Veterans Affairs gave approval to make available four buildings and 20 acres of land for the project.
In the summer of 2002, the Office of Secretary placed a hold on the enhanced use project pending the CARES planning process and the recommendations of a pilot assisted living project to be completed in early calendar 2004.
Attachments A, B and C are graphic descriptions showing the enhanced use lease project phases at Montrose as well as other vacant buildings that are now occupied by outside groups at both campuses. The NY State Veterans Nursing Home is also identified in the graphics as 23 acres of land was deeded to the State for construction of a 252-bed facility.
The plan for enhanced use leasing included in Option "A" gives HVHCS the unique opportunity to collect and retain revenues for vacant buildings and underutilized land anticipated to reach $18.5 million dollars for the period. This supplement to our budget will ensure continued services to Veterans for years to come and allows the entrepreneurial management of this resource benefiting the VA and the community at large.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN										
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Medicine	1,684	862	1,685	863	540	-	1,145	-	-	-	-	$	10,650,761
Surgery	110	(60)	111	(59)	111	-	-	-	-	-	-	$	(240,839)
Intermediate/NHCU	84,476	-	3,336	(81,140)	1,802	-	-	-	-	-	1,534	$	252,727,336
Psychiatry	28,766	1,662	3,799	(23,305)	3,799	-	-	-	-	-	-	$	117,410,536
PRRTP	48	-	48	-	-	-	-	-	-	-	48	$	(151,784)
Domiciliary	45,826	-	42,596	(3,230)	-	-	-	-	-	-	42,596	$	3,417,017
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$	-
Total	**160,910**	**2,464**	**51,575**	**(106,871)**	**6,252**	**-**	**1,145**	**-**	**-**	**-**	**44,178**	**$**	**383,813,027**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**										
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Primary Care	65,438	(1,366)	65,438	(1,366)	1,309	-	-	-	-	-	64,129	$	(3,319,032)
Specialty Care	70,487	37,386	52,017	18,916	-	-	-	-	-	-	52,017	$	16,365,771
Mental Health	80,042	1,068	44,856	(34,118)	-	-	-	-	-	-	44,856	$	29,306,023
Ancillary & Diagnostics	32,269	17,334	4,512	(10,423)	4,512	-	-	-	-	-	-	$	25,547,259
Total	**248,235**	**54,421**	**166,823**	**(26,991)**	**5,821**	**-**	**-**	**-**	**-**	**-**	**161,002**	**$**	**67,900,021**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	2,383	2,383	-	-	-	-	-	-	-	-	-	-
Surgery	59	59	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	-	(48,678)	-	(48,678)	48,678	-	-	-	-	-	48,678	48,678
Psychiatry	46,601	12,701	-	(33,900)	33,900	17,000	-	-	-	-	50,900	50,900
PRRTP	-	-	228	228	-	-	-	-	-	-	-	(228)
Domiciliary program	57,438	-	53,390	(4,048)	57,438	-	-	-	-	-	57,438	4,048
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**106,481**	**(33,535)**	**53,618**	**(86,398)**	**140,016**	**17,000**	**-**	**-**	**-**	**-**	**157,016**	**103,398**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	32,065	18,014	32,064	18,013	14,051	20,000	-	-	-	-	34,051	1,987
Specialty Care	72,885	63,220	57,219	47,554	9,665	60,000	-	-	-	-	69,665	12,446
Mental Health	43,583	35,257	24,671	16,345	8,326	25,000	-	-	-	-	33,326	8,655
Ancillary and Diagnostics	28,810	(3,244)	-	(32,054)	32,054	-	-	-	-	-	32,054	32,054
Total	**177,342**	**113,246**	**113,954**	**49,858**	**64,096**	**105,000**	**-**	**-**	**-**	**-**	**169,096**	**55,142**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	3,370	-	-	(3,370)	3,370	-	-	-	-	-	3,370	3,370
Administrative	339,230	129,550	47,110	(162,570)	209,680	-	-	-	-	-	209,680	162,570
Other	130,549	-	-	(130,549)	130,549	-	-	-	-	-	130,549	130,549
Total	**473,149**	**129,550**	**47,110**	**(296,489)**	**343,599**	**-**	**-**	**-**	**-**	**-**	**343,599**	**296,489**

6. Facility Level Information – New York Harbor

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

A. Proximity: 60 Mile Acute ServicesVA NYHHS was advised to consider mission changes and/or realignment of acute care facilities in the Metro NY market. Data suggests 99 fewer acute care beds (medicine, surgery and psychiatry) will be needed in 2022 among these sites NYHHS: NY & BK;BRX & NYHHS: NY;BRX & NYHHS: BK.Several alternatives for this PI were considered. After two rounds of stakeholder review and input, the plan selected is as follows:At present, acute care (ER, ICU, and acute medical, surgical and psychiatric) services are provided at both the Brooklyn and New York campuses. The NYHHS share of the acute care bed gap is 76 beds. Enrollment trends show an increased demand for acute care beds by our veteran users suggesting a shortfall of 17 beds by FY12. For the period leading to FY12, our market should plan for dealing with the transient need for acute care services by improving efficiency and decreasing length of stay at both of our acute care campuses. Considers access needs for patients, given the significant transportation issues in this market

B. Proximity Issue: 120 mile Tertiary Care ServicesAmongst the three tertiary care sites in the Metro New York Market, we were advised to consider Mission changes between NYHHS: Brooklyn and New YorkBronx & NYHHS (either campus)Several alternatives for this PI were considered. After two rounds of stakeholder review and input, the plan selected is as follows:Tertiary care is a highly specialized medical service. At present the Bronx site specializes in SCI, while the NYHHS specializes in Invasive Cardiology, Cardiac Surgery, Neurosurgical Care, and Oncologic Care among others. NYHHS will not provide SCI care. The ability to provide quality acute care services for inpatients and specialty care services for outpatients is closely linked with the strength of

our academic affiliations. Each affiliate (SUNY Downstate: Brooklyn Campus; NYU School of Medicine: New York Campus) must see a benefit in preserving and enhancing their commitments to VA NYHHS and the veterans that we serve. Therefore the current division of tertiary care services should be maintained at the NY Campus (Invasive Cardiology, Cardiac Surgery, Neurosurgery and VISN-3 tertiary care referral site for all invasive cardiology, cardiac surgery, and neurosurgery). Oncology services will remain at the Brooklyn Campus where a newly renovated Radiation Oncology Unit and special in- and outpatient units for cancer chemotherapy and palliative care are located. BK Campus has been designated as the site for construction of a Fisher House to accommodate the families of veterans receiving acute and/or tertiary care treatment on its oncology units or at other campuses of NYHHS. In addition, other special surgical services should be divided such that duplicative tertiary services are not provided at each site.This was the preferred plan as suggested by stakeholder feedback:

+ Continue to maintain the strategic plan to provide non-duplicative tertiary care. It works well.
+ Patients have an "ownership" in their hospital. This plan supports that local facility feeling.
+ Supports an important academic relationship
+ Considers major traffic conditions that will have greatest impact on elderly and frail patients. Please refer to the entire Proximity Plan posted on the VSSC Portal

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Imapct

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

1. The VISN 3 CARES Committee, Facility and VISN level leadership has activity engaged DoD throughout the CARES process. This includes involving two DoD participants to the internal VISN 3 CARES Committee from Health Affairs, TRICARE Region 1. They had access and information on all developmental aspects of the CARES Market Plan and provided valuable assistance and insight. To speak to the specific VA/DoD initiatives identified by the National CARES Process please see the specific initiative and status bulleted below:

   § VA New Jersey HCS and Ft. Monmouth, NJ Collaboration – We are happy to announce due to the CARES process and with the support of the DoD and congressional support within New Jersey, VISN 3 has been approved to site an active CBOC on the Ft. Monmouth, NJ site. This is anticipated to open sometime after June FY 03.

   § VA New York Harbor HCS (Brooklyn Campus) and Ft. Hamilton Army Base – This collaboration has occurred over the years, and the Brooklyn Campus is thought to be one of the more active VA/DoD sharing activities within the Northeast Region. The Ft. Hamilton Army Base abuts the Brooklyn Campus and the Ainsworth Clinic that supports the Army Garrison and the Brooklyn Campus has worked together organizationally for a number of years. In fact, one of the senior physicians at the clinic is a part-time DoD employee and part-time VA employee. As a result of the CARES initiative, aside of further collaboration is an important designation of the site to be "co-located". This will offer additional support to development of healthcare providing services to both DoD and VA beneficiaries.

   § VA Hudson Valley HCS and West Point/Keller Army Medical Center – Through the CARES process, the leadership has worked with the West Point command and did not meet with the high level of success as the New Jersey and Brooklyn initiatives. This is due to the very different missions of the facilities, specifically Montrose is a long-term psychiatry/ Domiciliary/Homeless etc. and West Point is training the young future leaders of DoD. Additionally, during the CARES process the West Point – Keller AMC leadership changed and slowed down local discussions.

The commitment of both organizations is to find common services and to work to develop agreements to enhance services to the beneficiaries.

2. Investigate joint resident training in active agreements and collaborations.

3. Review High Tech/High Cost equipment inventories (e.g. MRI, Pet Scanners, IRM services, etc.) for possible joint VA/DoD actions.

4. Review support services (e.g. laundry, medical incinerators, etc.) for possible joint VA/DoD actions.

5. Emergency Preparedness – including continuing supporting reservists activated in the days after 9/11 and active collaboration with DoD and other local state and federal agencies related to preparedness.

6. Possibility for Joint Research collaboration.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	22,625	(1,324)	22,626	(1,323)	-	-	-	-	-	-	22,626	$ (3,751,278)
Surgery	5,421	(512)	5,421	(512)	-	-	-	-	-	-	5,421	$ (833,617)
Intermediate/NHCU	3,100	-	197	(2,903)	-	-	-	-	-	-	197	$ 28,425,641
Psychiatry	9,739	1,363	9,739	1,363	641	-	-	-	-	-	9,098	$ 4,432,067
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	4,118	-	4,118	-	-	-	-	-	-	-	4,118	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**45,003**	**(473)**	**42,101**	**(3,375)**	**641**	**-**	**-**	**-**	**-**	**-**	**41,460**	**$ 28,272,813**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	135,125	60,515	135,125	60,515	-	-	-	-	-	-	135,125	$ (8,435,841)
Specialty Care	150,654	34,594	150,655	34,595	1,600	-	-	-	-	-	149,055	$ (38,884,510)
Mental Health	90,382	(127)	90,382	(127)	-	-	-	-	-	-	90,382	$ (1,968,264)
Ancillary & Diagnostics	205,926	69,125	205,926	69,125	-	-	-	-	-	-	205,926	$ (12,028,885)
Total	**582,087**	**164,107**	**582,088**	**164,108**	**1,600**	**-**	**-**	**-**	**-**	**-**	**580,488**	**$ (61,317,500)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	55,886	10,858	55,886	10,858	45,028	18,000	-	-	-	-	63,028	7,142
Surgery	8,999	4,519	8,999	4,519	4,480	4,000	-	-	-	-	8,480	(519)
Intermediate Care/NHCU	5,549	5,549	-	-	-	-	-	-	-	-	-	-
Psychiatry	15,777	9,820	14,739	8,782	5,957	-	15,000	-	-	-	20,957	6,218
PRRTP	-	(9,600)	-	(9,600)	9,600	-	-	-	-	-	9,600	9,600
Domiciliary program	5,148	5,148	5,148	5,148	-	-	-	-	-	-	-	(5,148)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**91,359**	**26,294**	**84,772**	**19,707**	**65,065**	**22,000**	**15,000**	**-**	**-**	**-**	**102,065**	**17,293**

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plan									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	95,939	43,228	95,939	43,228	52,711	-	30,000	-	-	-	82,711	(13,228)
Specialty Care	165,721	72,454	163,960	70,693	93,267	-	65,000	-	-	-	158,267	(5,693)
Mental Health	49,710	17,477	49,710	17,477	32,233	17,000	-	-	-	-	49,233	(477)
Ancillary and Diagnostics	154,445	62,050	154,444	62,049	92,395	-	40,000	-	-	-	132,395	(22,049)
Total	**465,814**	**195,208**	**464,053**	**193,447**	**270,606**	**17,000**	**135,000**	**-**	**-**	**-**	**422,606**	**(41,447)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	21,646	-	-	(21,646)	21,646	-	-	-	-	-	21,646	21,646
Administrative	318,350	122,813	301,914	106,377	195,537	-	-	-	-	-	195,537	(106,377)
Other	57,148	-	57,148	-	57,148	-	-	-	-	-	57,148	-
Total	**397,144**	**122,813**	**359,062**	**84,731**	**274,331**	**-**	**-**	**-**	**-**	**-**	**274,331**	**(84,731)**

7. Facility Level Information – New York

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

A. Proximity: 60 Mile Acute ServicesVA NYHHS was advised to consider mission changes and/or realignment of acute care facilities in the Metro NY market. Data suggests 99 fewer acute care beds (medicine, surgery and psychiatry) will be needed in 2022 among these sites NYHHS: NY & BK;BRX & NYHHS: NY;BRX & NYHHS: BK.Several alternatives for this PI were considered. After two rounds of stakeholder review and input, the plan selected is as follows:At present, acute care (ER, ICU, and acute medical, surgical and psychiatric) services are provided at both the Brooklyn and New York campuses. The NYHHS share of the acute care bed gap is 76 beds. Enrollment trends show an increased demand for acute care beds by our veteran users suggesting a shortfall of 17 beds by FY12. For the period leading to FY12, our market should plan for dealing with the transient need for acute care services by improving efficiency and decreasing length of stay at both of our acute care campuses. Considers access needs for patients, given the significant transportation issues in this market

B. Proximity Issue: 120 mile Tertiary Care ServicesAmongst the three tertiary care sites in the Metro New York Market, we were advised to consider Mission changes between NYHHS: Brooklyn and New YorkBronx & NYHHS (either campus)Several alternatives for this PI were considered. After two rounds of stakeholder review and input, the plan selected is as follows:Tertiary care is a highly specialized medical service. At present the Bronx site specializes in SCI, while the NYHHS specializes in Invasive Cardiology, Cardiac Surgery, Neurosurgical Care, and Oncologic Care among others. NYHHS will not provide SCI care. The ability to provide quality acute care services for inpatients and specialty care services for outpatients is closely linked with the strength of

our academic affiliations. Each affiliate (SUNY Downstate: Brooklyn Campus; NYU School of Medicine: New York Campus) must see a benefit in preserving and enhancing their commitments to VA NYHHS and the veterans that we serve. Therefore the current division of tertiary care services should be maintained at the NY Campus (Invasive Cardiology, Cardiac Surgery, Neurosurgery and VISN-3 tertiary care referral site for all invasive cardiology, cardiac surgery, and neurosurgery). Oncology services will remain at the Brooklyn Campus where a newly renovated Radiation Oncology Unit and special in- and outpatient units for cancer chemotherapy and palliative care are located. BK Campus has been designated as the site for construction of a Fisher House to accommodate the families of veterans receiving acute and/or tertiary care treatment on its oncology units or at other campuses of NYHHS. In addition, other special surgical services should be divided such that duplicative tertiary services are not provided at each site.This was the preferred plan as suggested by stakeholder feedback:

+ Continue to maintain the strategic plan to provide non-duplicative tertiary care. It works well.
+ Patients have an "ownership" in their hospital. This plan supports that local facility feeling.
+ Supports an important academic relationship
+ Considers major traffic conditions that will have greatest impact on elderly and frail patients. Please refer to the entire Proximity Plan posted on the VSSC Portal

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN										
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Medicine	23,407	3,630	23,407	3,630	703	-	-	-	-	-	22,704	$	(4,584,895)
Surgery	14,355	(144)	14,356	(143)	-	-	-	-	-	-	14,356	$	(1,875,639)
Intermediate/NHCU	6,574	-	6,574	-	2,301	-	-	-	-	-	4,273	$	-
Psychiatry	17,113	2,267	17,114	2,268	787	-	-	-	-	-	16,327	$	(6,262,426)
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$	-
Domiciliary	-	-	-	-	-	-	-	-	-	-	-	$	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$	-
Total	**61,449**	**5,753**	**61,451**	**5,755**	**3,791**	**-**	**-**	**-**	**-**	**-**	**57,660**	**$**	**(12,722,960)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**										
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**	
Primary Care	141,887	50,966	141,887	50,966	11,351	-	-	-	-	-	130,536	$	(5,905,089)
Specialty Care	140,370	25,469	140,370	25,470	8,615	-	-	-	-	-	131,755	$	6,126,282
Mental Health	72,168	54	72,168	54	-	-	-	-	-	-	72,168	$	1,994,371
Ancillary & Diagnostics	136,961	35,964	136,962	35,965	2,740	-	-	-	-	-	134,222	$	-
Total	**491,386**	**112,453**	**491,387**	**112,454**	**22,706**	**-**	**-**	**-**	**-**	**-**	**468,681**	**$**	**2,215,564**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	54,492	17,484	54,490	17,482	37,008	22,000	-	-	-	-	59,008	4,518
Surgery	23,831	6,281	23,831	6,281	17,550	9,000	-	-	-	-	26,550	2,719
Intermediate Care/NHCU	7,649	7,649	7,649	7,649	-	-	-	-	-	-	-	(7,649)
Psychiatry	29,715	12,085	29,225	11,595	17,630	-	20,000	-	-	-	37,630	8,405
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	-	-	-	-	-	-	-	-	-	-	-	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**115,686**	**43,498**	**115,195**	**43,007**	**72,188**	**31,000**	**20,000**	**-**	**-**	**-**	**123,188**	**7,993**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	69,184	18,918	69,184	18,918	50,266	-	21,000	-	-	-	71,266	2,082
Specialty Care	148,231	10,344	144,930	7,043	137,887	-	-	-	-	-	137,887	(7,043)
Mental Health	38,502	7,713	39,692	8,903	30,789	-	-	-	-	-	30,789	(8,903)
Ancillary and Diagnostics	99,325	(4,601)	99,324	(4,602)	103,926	-	-	-	-	-	103,926	4,602
Total	**355,241**	**32,373**	**353,130**	**30,262**	**322,868**	**-**	**21,000**	**-**	**-**	**-**	**343,868**	**(9,262)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	57,561	-	90,001	32,440	57,561	-	32,380	-	-	-	89,941	(60)
Administrative	280,099	41,519	292,142	53,562	238,580	-	-	-	-	-	238,580	(53,562)
Other	46,793	-	46,793	-	46,793	-	-	-	-	-	46,793	-
Total	**384,453**	**41,519**	**428,936**	**86,002**	**342,934**	**-**	**32,380**	**-**	**-**	**-**	**375,314**	**(53,622)**

8. Facility Level Information – St. Alban's

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

No Impact

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

The St. Albans Campus of VA NY Harbor Healthcare System (NYHHS) is projected to have <40 acute care beds, however the site fulfills a long-term care mission. Site is also designated for enhanced use considerations.Several alternatives to blending this PI with the outpatient primary and specialty care PIs for this market were considered. After two rounds of stakeholder review and input, the plan selected is as follows:The St. Albans site has the most acreage for development. Raze all buildings except Pratt Auditorium. Construct a new, modern, efficient NHCU facility to accommodate 180 beds. Seek contract services in the community to provide NHCU services for any future LTC bed needs. Adjacent to the NHCU site, a new outpatient site should be built to accommodate the projected needs for primary and specialty care in Queens County. Make allowances to accommodate domiciliary needs at current levels (50 beds) either in a separate building or in a contiguous wing of the NHCU. Designate some acreage to developers, for enhanced use to serve veterans' housing or assisted living needs for veterans. Use remaining acreage for green/open space.Stakeholder input is summarized as follows:

+ Bold plan, consistent with CARES VETPOP and enrollee projections for Queens County.
+ Proposal will solve SE Metro NY market vacant space PI in one project.
+ Expected to lower long-term operational facility costs.
+ Consider excess land for assisted living quarters for veterans and family.
+ Addresses Market and VISN need for LTC beds.
+ Contracting NHCU beds considers vets who may not want placement a long distance from family support systems.
+ Commits resources to a currently under served market.
+ Elected officials for the St. Albans area strongly supports community involvement in the CARES process.

Full funding might not be provided for such a bold project. Neighboring Community Association expressed concern over destruction of a perceived historical building and the potential development of low income housing on the site.Other possible plans were:1. The St. Albans site has sufficient square feet to handle projected NHCU needs. Completely renovate and

modernize the existing site to accommodate a minimum of 180 beds. Seek contract services in the community to provide NHCU services for any future LTC bed needs. Renovate and/or increase remaining sections to handle the projected increase in primary care needs and expected specialty care needs. Demolish any remaining unused space. Designate some acreage to developers, for enhanced use to serve veterans' housing or assisted living needs. Use remaining acreage for green/open space2. Renovate the NYHHS: Brooklyn Campus, to accommodate a 180 bed NHCU. Seek contract services in the community to provide NHCU services for any future LTC bed needs. Raze all existing buildings at the St. Albans campus. Construct a new outpatient service facility to handle primary and specialty care needs. Designate enhanced use status for remaining St. Albans property for veteran housing needs. Use remaining acreage for green/open spaceStakeholders commented that these plans would likely decrease the quality of care and that market penetration would decline.What is clear is that through demolition of excess and unused buildings at this campus, the vacant space PI for the market will be more than adequately addressed.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	1	(1)	1	(1)	1	-	-	-	-	-	-	$ (18,663)
Surgery	1	(1)	1	(1)	1	-	-	-	-	-	-	$ (6,235)
Intermediate/NHCU	154,193	-	157,096	2,903	94,258	-	-	-	-	-	62,838	$ (32,292,197)
Psychiatry	-	-	-	-	-	-	-	-	-	-	-	$ -
PRRTP	-	-	-	-	-	-	-	-	-	-	-	$ -
Domiciliary	15,437	-	18,667	3,230	-	-	-	-	-	-	18,667	$ (11,989,362)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**169,632**	**(2)**	**175,765**	**6,131**	**94,260**	**-**	**-**	**-**	**-**	**-**	**81,505**	**$ (44,306,457)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	26,108	2,703	26,109	2,704	-	-	-	-	-	-	26,109	$ -
Specialty Care	35,262	21,584	35,263	21,585	-	-	-	-	-	-	35,263	$ (5,383,779)
Mental Health	3,575	71	3,576	72	-	-	-	-	-	-	3,576	$ -
Ancillary & Diagnostics	8,132	4,419	8,132	4,419	-	-	-	-	-	-	8,132	$ -
Total	**73,077**	**28,777**	**73,080**	**28,780**	**-**	**-**	**-**	**-**	**-**	**-**	**73,080**	**$ (5,383,779)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	2	2	-	-	-	-	-	-	-	-	-	-
Surgery	2	2	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	79,362	-	80,856	1,494	79,362	-	80,000	-	-	-	159,362	78,506
Psychiatry	-	(10,804)	-	(10,804)	10,804	-	-	-	-	-	10,804	10,804
PRRTP	-	-	-	-	-	-	-	-	-	-	-	-
Domiciliary program	12,292	-	14,864	2,572	12,292	-	-	-	-	-	12,292	(2,572)
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**91,658**	**(10,800)**	**95,720**	**(6,738)**	**102,458**	**-**	**80,000**	**-**	**-**	**-**	**182,458**	**86,738**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	19,582	(4,482)	19,582	(4,482)	24,064	-	-	-	-	-	24,064	4,482
Specialty Care	40,905	32,952	40,905	32,952	7,953	30,000	-	-	-	-	37,953	(2,952)
Mental Health	2,968	(417)	2,968	(417)	3,385	-	-	-	-	-	3,385	417
Ancillary and Diagnostics	7,807	(9,409)	7,807	(9,409)	17,216	-	-	-	-	-	17,216	9,409
Total	**71,262**	**18,644**	**71,262**	**18,644**	**52,618**	**30,000**	**-**	**-**	**-**	**-**	**82,618**	**11,356**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	-	-	-	-	-	-	-	-	-	-	-	-
Administrative	184,099	9,516	185,783	11,200	174,583	-	-	-	-	-	174,583	(11,200)
Other	16,583	-	16,583	-	16,583	-	-	-	-	-	16,583	-
Total	**200,682**	**9,516**	**202,366**	**11,200**	**191,166**	**-**	**-**	**-**	**-**	**-**	**191,166**	**(11,200)**

C. New Jersey Market

1. Description of Market

a. Market Definition

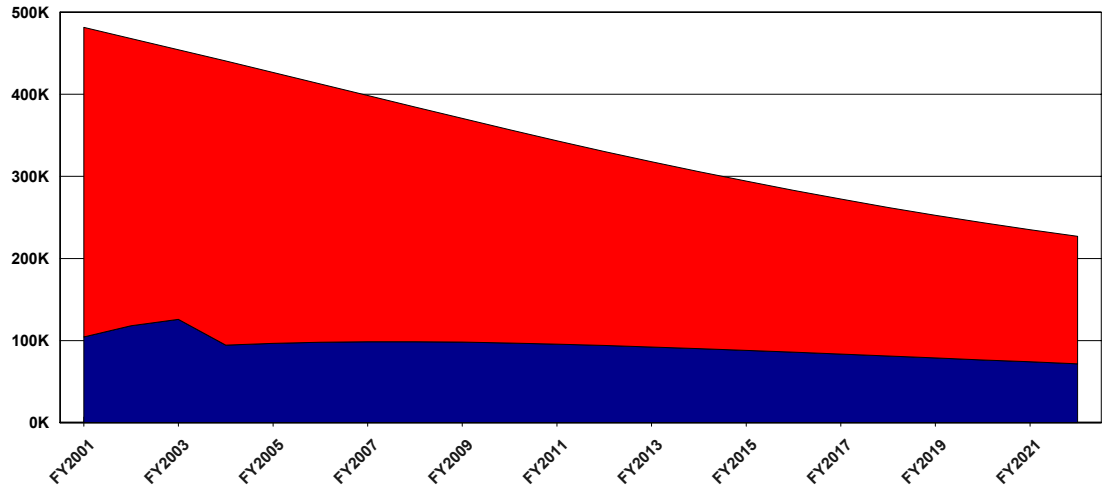
Market	Includes	Rationale	Shared Counties
VA New Jersey Healthcare Market **Code: 3C**	14 New Jersey Counties	The VA New Jersey Healthcare Market was constructed based upon an analysis of referral patterns supporting 358,000 veterans. The usage patterns are more absolute within VA New Jersey Healthcare Market than the VA Metro New York healthcare population. This market has one (two-campus) healthcare system and eight community clinics.	

b. Facility List

VISN : 3				
Facility	**Primary**	**Hospital**	**Tertiary**	**Other**
Lyons				
561A4 Lyons	✔	✔	-	-
VA New Jersey HCS				
561 New Jersey HCS (East Orange)	✔	✔	✔	-
561BZ Brick	✔	-	-	-
561GA Trenton	✔	-	-	-
561GB Elizabeth	✔	-	-	-
561GD Hackensack/Bergen County	✔	-	-	-
561GE Jersey City	✔	-	-	-
561GF New Brunswick	✔	-	-	-
561GG Newark	✔	-	-	-
561GH Morristown	✔	-	-	-

c. Veteran Population and Enrollment Trends

----- **Projected Veteran Population** ----- **Projected Enrollees**



d. List of All Planning Initiatives & Collaborative Opportunities

CARES Categories Planning Initiatives						
New Jersey Market			Februrary 2003 (New)			
Market PI	Category	Type Of Gap	FY2012 Gap	FY2012 %Gap	FY2022 Gap	FY2022 %Gap
N	Access to Primary Care					
N	Access to Hospital Care					
N	Access to Tertiary Care					
Y	Outpatient Specialty Care	Population Based	217,271	156%	132,589	95%
		Treating Facility Based	185,002	146%	112,220	88%
Y	Outpatient Primary Care	Population Based	143,784	97%	66,879	45%
		Treating Facility Based	120,564	88%	54,138	39%
Y	Inpatient Medicine	Population Based	56	83%	21	32%
		Treating Facility Based	53	84%	21	33%
Y	Inpatient Psychiatry	Population Based	41	27%	18	12%
		Treating Facility Based	41	27%	20	13%
N	Inpatient Surgery	Population Based	16	60%	4	15%
		Treating Facility Based	14	65%	4	18%
N	Outpatient Mental Health	Population Based	N/A	N/A	N/A	N/A
		Treating Facility Based	N/A	N/A	N/A	N/A

e. Stakeholder Information

Discussion of stakeholder input and how concerns/issues were addressed.

Stakeholder Narrative:

Stakeholders supporting the New York/New Jersey Veterans Integrated Service Network (VISN 3) have been kept involved and informed throughout the progression of the CARES process. The VISN staff held regular briefings with Network-level groups such as the Management Assistance Council, numerous VISN level committees such as the Executive Leadership Council. Communication modes consisted of face-to-face briefings, distribution of newsletters and bulletins, e-mails, mailings (newsletters), conference calls, employee meetings and website postings. At the Market level, a wide variety of stakeholders have been extensively briefed, consulted and involved -, including veterans service organizations, veterans groups, medical school affiliates, staff members and volunteers, local stakeholders, and union representatives. Information has been provided to these groups through town hall meetings, employee newsletters, e-mail notices, mailings, committee and staff meetings, Dean's Committee meetings, and veteran council meetings. Comments were solicited through these forums as well as through encouragement of phone calls, letters, and the VISN Internet and Intranet websites.

Overall, the process has been viewed positively from the stakeholders. Some of the more frequent comments and questions included (with Network responses in parentheses):

1. Concern about possible facility closures, Small Facility PI and Proximity PI — (Comments from stakeholders were considered in the development of final proposed plan)

2. Concerns over multi-VISN coordination of SCI Services – (VISN 3 coordinated internal discussions with referring VISN's to develop a comprehensive plan which included planning from VISN's 2 and 4). (Participated in EPVA and PVA sponsored meetings)

3. Outreach to all stakeholders though all modes of communication exceeded 330,000 contacts.

4. Whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

5. Potential impact of war on data projections. (Present data projections do not include potential war impact, however, data will be re-run on an annual basis and adjustments made as needed. This is a long-term strategic planning process.)

Extensive efforts were made to educate our stakeholders, such as briefing on the IBM planning model, in depth discussions of the CARES process and our approach to meeting the timeframes and objectives of the program. Input provided by our stakeholders was considered throughout the CARES planning process by the individual facilities, markets and at the VISN levels.

Of particular note is VISN 3's leadership in bringing together 3 VISNs along with the EPVA and PVA to address the overall plan for SCI Care in the Northeast. This included several meetings and calls in addition to one face to face meeting with VISNs 2,3,4 and the EPVA, PVA and Dr. Hammond from VACO – which was hosted by the EPVA.

f. Shared Market Discussion

Detailed info at the facility level for this specific market. Include any linkages with other VISNs for Shared Markets.

Shared Market Narrative:

Background: SCI projection models were developed through the combined efforts of SCI&D SHG officials and the Office of the Actuary (OACT) in collaboration with the National CARES Program Office (NCPO).

The model recommended is based upon actual FY01 SCI 'user-enrollees' as a market share of the prevalence model estimates based upon zip code mapping of actual FY01 SCI enrollees who have used VHA at any time since 1988. By linking the current user-enrollees to the CARES demographic VetPop databases by VISN, projected utilization is derived by calculating a market share of priority groups 1-4 prevalence estimates (based upon Lasfarques et al., 1995) plus 25% of veterans with multiple sclerosis based on state latitude adjusted VISN multiple sclerosis prevalence rates based on Bandolier (2001) and Myhr et al. (2001).

Within the Northeast corridor, VISN 1 has a comprehensive SCI program within the greater Boston area located at the West Roxbury facility and supports the New England region. This led to the recommendation affecting VISN 3, which read:

"Other CARES planning issues relate to potential mission changes in VISN 3 for facilities that may affect SCI beds. The Chief Consultant, SCI&D, should work closely with VISN 3 planners and neighboring VISN's (especially VISN's 2 and 4) to facilitate appropriate planning for any bed relocations."

As a result of this recommendation and the evaluation of the projections for SCI/D - we initiated meetings and conference calls with the Chief Consultant, SCI&D on February 19, 2003 to discuss an approach and to solicit her guidance.

On March 3, 2003 VISN 3 coordinated the first discussion between the senior leadership of VISN's 2, 3 and 4 to discuss the Spinal Cord Injury programs referral patterns and outline plans that have been developed based on existing CARES data to ensure these plans do not conflict with plans being put forward at other VISN's. Also to develop a strategic approach to Acute and LTC SCI beds, allocation of beds and impact of the opening of the SCI program in VISN 2 or VISN 4. Based on these discussions VISN 3 developed the approach to consolidate all SCI/D patient treatment at center of excellence to be located at the VA Medical Center, Bronx, NY. In effect, this would consolidate the three SCI programs within VISN 3 into one comprehensive unit. This plan was presented at the follow-up conference call with our neighboring VISN's on 3/28/03. Concurrently, during this period the EPVA had organized a face-to-face meeting in their Queens, NY offices to discuss the coordination efforts and referral patterns between the VISN's, which was well attended by all of the participating VISN's.

On April 4, 2003, VISN's 2,3 and 4 participated in a conference call along with Chief Consultant, SCI&D and the senior leadership of the EPVA and PVA. VISN's 2,3 and 4 outlined our plans which had been coordinated and discussed at which time we presented our preferred option to address this planning initiative which based on our analysis and discussions with referring VISN's and stakeholders, VISN 3 concluded the best approach to take in developing the CARES market plan for SCI is to shift all workload to the VA Medical Center Bronx, NY.

Proposal:

Network 3 proposes consolidating all acute inpatient Spinal Cord Injury Services at the Bronx VAMC by 2006. This would increase the number of acute care SCI beds at the Bronx VAMC from 62 to 66. A full spectrum of SCI outpatient care will be provided at two of the existing locations, the Bronx VAMC and the East Orange VAMC. Extended care services will be provided in 30 beds dedicated to SCI at the Bronx. There will be no decrease in the number of SCI Patients treated and no decrease in the number of beds to care for the SCI veterans it will remain 96 total beds.

This presentation was generally supported based on the discussion.

g. Overview of Market Plan

Detailed info at the facility level for this specific market. Include strengths, weaknesses, opportunities and potential obstacles associated with the Market Plan.

Executive Summary Narrative:

VA New Jersey Health Care System Executive Summary

1996

- Integrated the VAMC East Orange and VAMC Lyons into the VANJ Healthcare System
- Developed 10 bed Hoptel Program
- Closed 2 Intermediate Medicine wards, One Psychiatric ward and one Alcohol Rehabilitation ward at East Orange
- Closed 51 Psychiatric and 4 Intermediate Care beds at the Lyons campus
- Increase patients enrolled in Primary care from 5,000 to 30,000
- Consolidated Patient Data base into one
- Entered into agreement with Medical Center of Ocean County to provide mammography services and stat laboratory tests to patients at the James J. Howard Clinic in Brick, NJ
- Implemented Telephone Liaison program
- Reorganized Ward Administration from MAS to Nursing
- Integrated Delivery of Supplies and Mail to Acquisition and Material Management (A&MM) Service
- Reorganized SPD from A&MM Service to Nursing
- Remodeled and Expanded ER at EO to accommodate more patients and obviate the need for admission, particularly those suffering from Alcohol Intoxication
- Established a stakeholder advisory group, which included representation of veteran's service organization leaders and others for the purpose of including key individuals in matters involving veteran's health care.

1997

- Reorganized the Healthcare System by establishing product lines and integrated services
- Reduced 257 operating beds or 24% of the total as compared to October 1, 1996
- Increased surgeries performed on an ambulatory basis form 50% of the total to 70%
- Increased Outpatient visits by 3%
- Increased umber of unique veterans by nearly 3%

- Expanded Trenton CBOC
- Opened Ft. Dix CBOC in cooperation with Philadelphia VAMC
- Activated a state of the art Low Vision Center at the East Orange campus of the VANJ Healthcare System
- Closed the Laundry facility at Lyons and consolidated operations to St. Albans Queens as part of a VISN wide initiative.
- Established Asset Management Office to develop alternative revenue streams.

1998

- Centralized Intensive Care and Respiratory Care beds (15) from Lyons to East Orange
- Consolidated Rehabilitation beds at Lyons from 21 to 10 and collocated with Medical / Intermediate beds on ward 4A at Lyons
- Consolidated Intermediate wards 2A and 9A to 4B at Lyons
- Consolidated two psychiatric wards (STAR) at Lyons into one
- Collocated Mentally Ill Chemical Abuser (MICA) program at East Orange to existing Day Treatment Center in Newark, NJ
- Consolidated / Reorganized Facility Management – reduce FTEE by 29.5 FTEE
- Relocated Methadone Maintenance Clinic from Newark to East Orange
- Opened Elizabeth CBOC
- Reduced 254 operating beds or 21 % of the total as compared to October 1, 1997
- Increase the amount of outpatient visits by 4%
- Increase the number of unique veterans treated by 9%
- A new 180 bed psychiatric building at the Lyons campus was dedicated
- Reorganized ER at Lyons into a Walk In Center
- As a result of a survey conducted October 23-31, 1997 the VANJ Health Care System scored a 93 for the acute medical and surgical programs, 99 in Home Care, 99 in the Mental Health portion of the survey and a perfect 100 in our Nursing Home and long-term care areas. These scores are the highest marks ever achieved by either East Orange or Lyons
- Implemented an Advanced Food Delivery System at East Orange
- Through a combination of community partnerships and special funding from both VA and non-VA grants developed a continuum of care for homeless veterans. This resulted in the medical center being recognized by two (2) prestigious awards for assisting the building of the Greater NYC Consortium on Homeless Veterans. A co recipient of the National Performance Review's "Hammer" Award and the New Jersey Health Research and Education's Trust award for sustained community outreach efforts

1999

- Opened Jersey City CBOC
- Opened New Brunswick CBOC
- Established an Executive Consortium with our University affiliate, U

2. Resolution of Market Level Planning Initiatives: Access

Narrative on the impact on access to healthcare services, using VA standards when available.

- If you had an Access PI, describe all alternatives considered, identifying which ones were compared financially in the IBM application.
- Describe the impact on the percentage of the market area enrollees achieving standard travel distance/times for accessing different levels of care

Access Narrative:

No Impact

Service Type	Baseline FY 2001		Proposed FY 2012		Proposed FY 2022	
	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines	% of enrollees within Guidelines	# of enrollees outside access Guidelines
Primary Care	**93%**	8,062	**92%**	7,616	**91%**	6,418
Hospital Care	**83%**	19,257	**84%**	14,950	**84%**	11,639
Tertiary Care	**100%**	-	**100%**	-	**100%**	-

Guidelines:

Primary Care: Urban & Rural Counties – 30 minutes drive time
Highly Rural Counties– 60 minutes drive time

Hospital Care: Urban Counties – 60 minutes drive time
Rural Counties – 90 minutes drive time
Highly Rural Counties – 120 minutes drive time

Tertiary Care: Urban & Rural Counties – 4 hours
Highly Rural Counties – within VISN

3. Facility Level Information – Lyons

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

No Impact

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

1. The VISN 3 CARES Committee, Facility and VISN level leadership has activity engaged DoD throughout the CARES process. This includes involving two DoD participants to the internal VISN 3 CARES Committee from Health Affairs, TRICARE Region 1. They had access and information on all developmental aspects of the CARES Market Plan and provided valuable assistance and insight. To speak to the specific VA/DoD initiatives identified by the National CARES Process please see the specific initiative and status bulleted below:

   § VA New Jersey HCS and Ft. Monmouth, NJ Collaboration – We are happy to announce due to the CARES process and with the support of the DoD and congressional support within New Jersey, VISN 3 has been approved to site an active CBOC on the Ft. Monmouth, NJ site. This is anticipated to open sometime after June FY 03.
   § VA New York Harbor HCS (Brooklyn Campus) and Ft. Hamilton Army Base – This collaboration has occurred over the years, and the Brooklyn Campus is thought to be one of the more active VA/DoD sharing activities within the Northeast Region. The Ft. Hamilton Army Base abuts the Brooklyn Campus and the Ainsworth Clinic that supports the Army Garrison and the Brooklyn Campus has worked together organizationally for a number of years. In fact, one of the senior physicians at the clinic is a part-time DoD employee and part-time VA employee. As a result of the CARES initiative, aside of further collaboration is an important designation of the site to be "co-located". This will offer additional support to development of healthcare providing services to both DoD and VA beneficiaries.
   § VA Hudson Valley HCS and West Point/Keller Army Medical Center – Through the CARES process, the leadership has worked with the West Point command and did not meet with the high level of success as the New Jersey and Brooklyn initiatives. This is due to the very different missions of the facilities, specifically Montrose is a long-term psychiatry/ Domiciliary/Homeless etc. and West Point is training the young future leaders of DoD. Additionally, during the CARES process the West Point – Keller AMC leadership changed and slowed down local discussions. The commitment of both organizations is to find common services and to work to develop agreements to enhance services to the beneficiaries.

2. Investigate joint resident training in active agreements and collaborations.

3. Review High Tech/High Cost equipment inventories (e.g. MRI, Pet Scanners, IRM services, etc.) for possible joint VA/DoD actions.

4. Review support services (e.g. laundry, medical incinerators, etc.) for possible joint VA/DoD actions.

5. Emergency Preparedness – including continuing supporting reservists activated in the days after 9/11 and active collaboration with DoD and other local state and federal agencies related to preparedness.

6. Possibility for Joint Research collaboration.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

VBA Newark, NJ and VA New Jersey Health Care System (Lyons Campus) are in full agreement to collocate the Newark Regional Office to the Lyons Campus of the VA New Jersey Health Care System. Space currently exists at the Lyons campus however funds would be required to either renovate or construct new facilities to accommodate the personnel and space needs of the Regional Office. VBA has indicated that Lyons represents a suitable location for their program and would maintain a storefront operation in Newark to accommodate individuals who present themselves to that location and may be unable to reach the Lyons campus, located approximately 30 miles away from Newark off of Interstates 287 and 78. By collocating VBA on VHA property, it is felt that coordination of activities, particularly the large volume of Compensation and Pension examinations (currently averaging 650 exam requests per month) would be facilitated and would help in reducing the large backlog that currently exists at the Newark VBA. While the Secretary, Department of Veterans Affairs has endorsed this concept funding has not been appropriated at this point. VBA and VHA – VA New Jersey HCS continues to work together to develop and implement this initiative.

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

Potential uses: There is a significant and growing demand for residential land in northern New Jersey, and the subject is considered to be in a choice location for new residential development. Office use or an educational facility are also possible alternative uses.

Subdivision Potential: Several areas (including the golf course) can be subdivided, although wetland crossing and utility relocation may make this expensive. Local residents are very vocal and can be counted upon to be very involved with any development or subdivision plans. VA New Jersey HCS (Lyons Campus) has initiated action to develop an enhanced use lease for the 9-hole golf course.

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	132	(5)	132	(5)	-	-	-	-	-	-	132	$ -
Surgery	10	(18)	10	(18)	10	-	-	-	-	-	-	$ 207,976
Intermediate/NHCU	196,689	-	196,689	-	116,047	-	-	-	-	-	80,642	$ -
Psychiatry	45,588	6,006	45,589	6,007	-	-	-	-	-	-	45,589	$ (7,488,236)
PRRTP	7,780	-	7,780	-	-	-	-	-	-	-	7,780	$ -
Domiciliary	38,859	-	38,859	-	-	-	-	-	-	-	38,859	$ -
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	$ -
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**289,058**	**5,983**	**289,059**	**5,984**	**116,057**	**-**	**-**	**-**	**-**	**-**	**173,002**	**$ (7,280,260)**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	64,261	36,123	64,261	36,123	-	-	-	-	-	-	64,261	$ -
Specialty Care	87,065	52,548	87,065	52,548	-	-	-	-	-	-	87,065	$ (3,473,406)
Mental Health	66,422	(276)	66,423	(275)	-	-	-	-	-	-	66,423	$ -
Ancillary & Diagnostics	39,875	21,633	39,876	21,634	400	-	-	-	-	-	39,476	$ 675,057
Total	**257,623**	**110,028**	**257,625**	**110,030**	**400**	**-**	**-**	**-**	**-**	**-**	**257,225**	**$ (2,798,349)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)		Space (GSF) proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Medicine	275	275	275	275	-	-	-	-	-	-	-	(275)
Surgery	17	17	-	-	-	-	-	-	-	-	-	-
Intermediate Care/NHCU	99,165	-	99,164	(1)	99,165	-	-	-	-	-	99,165	1
Psychiatry	73,854	52,554	73,854	52,554	21,300	54,000	-	-	-	-	75,300	1,446
PRRTP	10,200	-	10,200	-	10,200	-	-	-	-	-	10,200	-
Domiciliary program	47,600	-	47,600	-	47,600	-	-	-	-	-	47,600	-
Spinal Cord Injury	-	-	-	-	-	-	-	-	-	-	-	-
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	-
Total	**231,110**	**52,845**	**231,093**	**52,828**	**178,265**	**54,000**	**-**	**-**	**-**	**-**	**232,265**	**1,172**
	Space (GSF) (from demand projections)		**Space (GSF) proposed by Market Plan**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Primary Care	41,770	(164)	41,770	(164)	41,934	-	-	-	-	-	41,934	164
Specialty Care	95,772	42,031	95,772	42,031	53,741	24,000	-	-	-	-	77,741	(18,031)
Mental Health	36,533	5,814	36,533	5,814	30,719	-	-	-	-	-	30,719	(5,814)
Ancillary and Diagnostics	38,281	1,266	37,897	882	37,015	-	-	-	-	-	37,015	(882)
Total	**212,355**	**48,946**	**211,972**	**48,563**	**163,409**	**24,000**	**-**	**-**	**-**	**-**	**187,409**	**(24,563)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance from 2001**	**Existing GSF**	**Convert Vacant**	**New Construction**	**Donated Space**	**Leased Space**	**Enhanced Use**	**Total Proposed Space**	**Space Needed/ Moved to Vacant**
Research	11,044	-	-	(11,044)	11,044	-	-	-	-	-	11,044	11,044
Administrative	299,976	68,014	262,423	30,461	231,962	-	-	-	-	-	231,962	(30,461)
Other	52,270	-	52,270	-	52,270	-	-	-	-	-	52,270	-
Total	**363,290**	**68,014**	**314,693**	**19,417**	**295,276**	**-**	**-**	**-**	**-**	**-**	**295,276**	**(19,417)**

4. Facility Level Information – New Jersey HCS

a. Resolution of VISN Level Planning Initiatives

Resolution Narrative of Proximity PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.
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- Discussion of Proposed PI in relation to the CARES criteria

Proximity Narrative:

Given the proximity of the East Orange facility of the VANJ Health Care System to the NY Harbor and Bronx VA Health Care Facilities it was determined there were three possible alternatives to resolving this issue. Senior management brainstormed the possible scenarios and presented them to various stakeholders throughout February, March and April 2003.This issue was discussed at a VISN wide meeting where it was felt that in all likelihood the mission of East Orange would not change due to the geographic distance from NY and that East Orange represented the only VA tertiary facility in the entire state. Any such reduction would not be accepted by veterans and would in fact represent a reduction of service and an inconvenience to travel to New York.The three (3) alternatives considered in priority order were:

A. Maintain EO as a tertiary care facility
B. Consolidate all tertiary care services to NY Harbor
C. Contract our for Tertiary care within the stateThe preferred option is A.

While the proximity of 120 miles is clearly not met the state boundaries are a compelling argument for maintaining the VANJ East Orange site as a tertiary facility serving the needs of NJ veterans. As the only such facility in the entire state it is unlikely that VANJ stakeholders will accept any substantive mission change.See attachment for impact of Options A, B and C on CARES criteria

Please refer to the entire Proximity Plan posted on the CARES Portal.

Resolution Narrative of Small Facility PI

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the current situation.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Describe the preferred alternative and its impact on the CARES Criteria.
- Provide more detail than provided at the Network level narrative. Describe actual changes planned at this particular facility.

Small Facility Narrative:

No Impact

DOD Collaborative Opportunities

Describe DOD Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

DOD Narrative:

1. The VISN 3 CARES Committee, Facility and VISN level leadership has activity engaged DoD throughout the CARES process. This includes involving two DoD participants to the internal VISN 3 CARES Committee from Health Affairs, TRICARE Region 1. They had access and information on all developmental aspects of the CARES Market Plan and provided valuable assistance and insight. To speak to the specific VA/DoD initiatives identified by the National CARES Process please see the specific initiative and status bulleted below:

§ VA New Jersey HCS and Ft. Monmouth, NJ Collaboration – We are happy to announce due to the CARES process and with the support of the DoD and congressional support within New Jersey, VISN 3 has been approved to site an active CBOC on the Ft. Monmouth, NJ site. This is anticipated to open sometime after June FY 03.

§ VA New York Harbor HCS (Brooklyn Campus) and Ft. Hamilton Army Base – This collaboration has occurred over the years, and the Brooklyn Campus is thought to be one of the more active VA/DoD sharing activities within the Northeast Region. The Ft. Hamilton Army Base abuts the Brooklyn Campus and the Ainsworth Clinic that supports the Army Garrison and the Brooklyn Campus has worked together organizationally for a number of years. In fact, one of the

senior physicians at the clinic is a part-time DoD employee and part-time VA employee. As a result of the CARES initiative, aside of further collaboration is an important designation of the site to be "co-located". This will offer additional support to development of healthcare providing services to both DoD and VA beneficiaries.

§ VA Hudson Valley HCS and West Point/Keller Army Medical Center – Through the CARES process, the leadership has worked with the West Point command and did not meet with the high level of success as the New Jersey and Brooklyn initiatives. This is due to the very different missions of the facilities, specifically Montrose is a long-term psychiatry/ Domiciliary/Homeless etc. and West Point is training the young future leaders of DoD. Additionally, during the CARES process the West Point – Keller AMC leadership changed and slowed down local discussions. The commitment of both organizations is to find common services and to work to develop agreements to enhance services to the beneficiaries.

2. Investigate joint resident training in active agreements and collaborations.

3. Review High Tech/High Cost equipment inventories (e.g. MRI, Pet Scanners, IRM services, etc.) for possible joint VA/DoD actions.

4. Review support services (e.g. laundry, medical incinerators, etc.) for possible joint VA/DoD actions.

5. Emergency Preparedness – including continuing supporting reservists activated in the days after 9/11 and active collaboration with DoD and other local state and federal agencies related to preparedness.

6. Possibility for Joint Research collaboration.

VBA Collaborative Opportunities

Describe VBA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

VBA Narrative:

No Impact

NCA Collaborative Opportunities

Describe NCA Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

NCA Narrative:

No Impact

Top Enhanced Use Market Opportunity

Describe EU Collaborative opportunities and how they support the resolution of workload or other Planning Initiatives. Briefly describe how they impact the CARES criteria.

Enhanced Use Narrative:

No Impact

Resolution of VISN Identified PIs

A narrative summary of proposed resolution and alternatives considered, with an overview of criteria.

- Describe the status Quo.
- Describe the preferred alternative and its impact on the CARES Criteria. Provide more detail than provided at the Network level narrative.
- Describe actual changes planned at this particular facility.
- List all alternatives considered. (Post narrative detail to the CARES portal)
- Discussion of Proposed PI in relation to the CARES criteria

VISN Identified Planning Initiatives Narrative:

No Impact

b. Resolution of Capacity Planning Initiatives

Proposed Management of Workload – FY 2012

	# BDOCs (from demand projections)		# BDOCs proposed by Market Plans in VISN									
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total BDOCs**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Medicine	36,010	16,509	36,010	16,509	361	-	-	-	-	-	35,649	$ (11,667,628)
Surgery	11,128	4,398	11,128	4,398	-	-	-	-	-	-	11,128	$ (6,200,649)
Intermediate/NHCU	31,232	-	31,232	-	24,361	-	-	-	-	-	6,871	$ (3,183,879)
Psychiatry	14,886	6,829	14,887	6,830	-	-	-	-	-	-	14,887	$ (4,467,871)
PRRTP	16	-	16	-	-	-	-	-	-	-	16	$ (223,742)
Domiciliary	495	-	495	-	-	-	-	-	-	-	495	$ -
Spinal Cord Injury	2,103	-	813	(1,290)	-	-	-	-	-	-	813	$ 26,677,178
Blind Rehab	-	-	-	-	-	-	-	-	-	-	-	$ -
Total	**95,870**	**27,736**	**94,581**	**26,447**	**24,722**	**-**	**-**	**-**	**-**	**-**	**69,859**	**$ 933,409**
	Clinic Stops (from demand projections)		**Clinic Stops proposed by Market Plans in VISN**									
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Total Stops**	**Variance from 2001**	**Contract**	**Joint Ventures**	**Transfer Out**	**Transfer In**	**In Sharing**	**Sell**	**In House**	**Net Present Value**
Primary Care	193,947	84,439	193,948	84,440	3,879	-	-	-	-	-	190,069	$ (13,591,078)
Specialty Care	224,752	132,452	224,752	132,453	14,496	-	-	-	-	-	210,256	$ (62,338,132)
Mental Health	65,511	843	65,512	844	-	-	-	-	-	-	65,512	$ 402,324
Ancillary & Diagnostics	292,155	148,542	292,155	148,542	-	-	-	-	-	-	292,155	$ (21,880,463)
Total	**776,365**	**366,276**	**776,367**	**366,278**	**18,375**	**-**	**-**	**-**	**-**	**-**	**757,992**	**$ (97,407,349)**

Proposed Management of Space – FY 2012

	Space (GSF) (from demand projections)											
INPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 2001**								**Space Needed/ Moved to Vacant**
Medicine	92,333	46,664	92,331	46,662	45,669	-	50,000	-	-	-	95,669	3,338
Surgery	27,820	17,295	27,820	17,295	10,525	-	19,000	-	-	-	29,525	1,705
Intermediate Care/NHCU	19,533	-	19,533	-	19,533	-	-	-	-	-	19,533	-
Psychiatry	29,625	17,845	29,625	17,845	11,780	-	22,000	-	-	-	33,780	4,155
PRRTP	-	-	76	76	-	-	-	-	-	-	-	(76)
Domiciliary program	7,773	-	7,773	-	7,773	-	-	-	-	-	7,773	-
Spinal Cord Injury	-	(11,681)	-	(11,681)	11,681	-	-	-	-	-	11,681	11,681
Blind Rehab	11,681	11,681	-	-	-	-	-	-	-	-	-	-
Total	**188,765**	**81,804**	**177,158**	**70,197**	**106,961**	**-**	**91,000**	**-**	**-**	**-**	**197,961**	**20,803**
	Space (GSF) (from demand projections)											
OUTPATIENT CARE	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 200**								**Space Needed/ Moved to Vacant**
Primary Care	96,935	64,852	96,935	64,852	32,083	-	60,000	-	-	-	92,083	(4,852)
Specialty Care	343,601	230,439	327,999	214,837	113,162	-	160,000	-	-	-	273,162	(54,837)
Mental Health	37,617	7,261	37,997	7,641	30,356	-	-	-	-	-	30,356	(7,641)
Ancillary and Diagnostics	186,979	117,271	186,979	117,271	69,708	-	90,000	-	-	-	159,708	(27,271)
Total	**665,132**	**419,823**	**649,910**	**404,601**	**245,309**	**-**	**310,000**	**-**	**-**	**-**	**555,309**	**(94,601)**
NON-CLINICAL	**FY 2012**	**Variance from 2001**	**Space Driver Projection**	**Variance f 200**								**Space Needed/ Moved to Vacant**
Research	69,717	-	36,086	(33,631)	69,717	-	-	-	-	-	69,717	33,631
Administrative	507,988	277,474	481,599	251,085	230,514	-	100,000	-	-	-	330,514	(151,085)
Other	46,554	-	46,554	-	46,554	-	-	-	-	-	46,554	-
Total	**624,259**	**277,474**	**564,239**	**217,454**	**346,785**	**-**	**100,000**	**-**	**-**	**-**	**446,785**	**(117,454)**